1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07480

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07456

1. PLACE OF DEATH
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 6 HRS.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MT. SAVAGE
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THOMAS — Middle GRIFFITH — Last ADAMS

4. DATE OF DEATH: Month JUNE — Day 30, — Year 19 67

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: DEC. 4, 1888

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months — Days

IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED-ACETATE DEPT.

10b. KIND OF BUSINESS OR INDUSTRY: CELANESE CORP

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE ADAMS

14. MOTHER'S MAIDEN NAME: EDITH GRIFFITH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 214-07-5155

17. INFORMANT — Address: MRS. ISABEL ADAMS, MT. SAVAGE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO (b): CORONARY SCLEROSIS — ----

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, or Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC MD.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): cumberland Md

22. DATE SIGNED: June 30, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: JULY 2, 1967

23c. NAME OF CEMETERY OR CREMATORY: METHODIST CEMETERY

23d. LOCATION (City or Town) (County) (State): MT. SAVAGE, MD.

24. FUNERAL DIRECTOR — ADDRESS: JOSEPH R. DURST, SR., FROSTBURG, MD

25a. RECD BY REGISTRAR — DATE: JUL 3 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07481 07457

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 16 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: RD#1, HOMEWOOD ADDITION
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SARAH Middle JANE Last ALBRIGHT
4. DATE OF DEATH: Month JUNE Day 24 Year 1967
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3-27-87
9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Bedford County, Penna. LITTLE ORLEANS, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JOHN ~~ALBRIGHT~~ DIEHL
14. MOTHER'S MAIDEN NAME: MARY J. ~~HOPENGARDNER~~ HOOPENGARDNER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: 220-03-7508
17. INFORMANT Address: HOSPITAL RECORD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ADENOCARCINOMA OF THE STOMACH — INTERVAL BETWEEN ONSET AND DEATH: 2 MO.
151X
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): ABDOMINAL CARCINOMATOSIS — 2 MO.
DUE TO (c): ARTERIOSCLEROTIC HEART DISEASE — 20 YRS.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): GENERALIZED ARTERIOSCLEROSIS ADVANCED AGE
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): NONE
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): NONE
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from JUNE 1, 1967 to JUNE 24, 1967, that (I) (we) last saw the deceased alive on JUNE 24, 1967, and that death occurred at 9.30 PM, from the causes and on the date stated above.

22a. SIGNATURE: James P. Hallinan M.D. M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6-25-67
22c. PHYSICIAN'S NAME (Type): DR. JAMES P. HALLINAN
22d. ADDRESS: 140 BEDFORD ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/27/67
23c. NAME OF CEMETERY OR CREMATORY: Fairview Christian Cemetery
23d. LOCATION (City, town or county) (State): Artemas, Penna.

24. FUNERAL DIRECTOR: JOHN J. HAFER FUNERAL HOME ADDRESS: 230 BALT. AVE.
25a. REC'D BY REGISTRAR DATE: JUN 28 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

ALLEGANY MARYLAND ALLEGANY

CUMBERLAND 10 DAYS CUMBERLAND

SACRED HEART HOSPITAL [illegible], MCKINLEY ADDITION

BOWAH JANE ALBRIGHT JUNE 24 47

FEMALE WHITE S 2-27-47 CO

HOUSEWIFE LITTLE CRESCENT, [illegible].C.O.

JOHN ALBRIGHT MARY J. [illegible]

NO 220-02-7300 HOSPITAL RECORDS

ADENOCARCINOMA OF THE STOMACH 2 MO.

ABDOMINAL CARCINOMATOSIS 2 MO.

ARTERIOSCLEROTIC HEART DISEASE 10 YRS.

GENERALIZED ARTERIOSCLEROSIS ADVANCED AGE

NONE

JUNE 1, 57 JUNE 24, 57

JUNE 24, 57 3:20 PM

2-23-57

DR. JAMES F. HOLLIMAN 140 BROADWAY ST., CUMBERLAND, MD.

JOHN J. HAGEN FUNERAL HOME, 220 [illegible]. AVE.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07482

CERTIFICATE OF DEATH

07458

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 4 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: Furnace St. Ext.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle: Naomi; Last: Arnold

4. DATE OF DEATH: Month: June; Day: 7; Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 3, 1885

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Keyser, W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Stingley Sears

14. MOTHER'S MAIDEN NAME: Leah Kopp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 220-52-9745

17. INFORMANT: Raymond F. Arnold — Address: 1025 Harding Avenue Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro - Vascular accident — INTERVAL BETWEEN ONSET AND DEATH: yrs
DUE TO
(b): Arteriosclerosis — yrs
DUE TO
(c): Hypertension — yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 331 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 9, 1967, to June 7, 19 67 that (I) (we) last saw the deceased alive on June 7 1967, and that death occurred at 10:20 A.M., from causes and on the date stated above.

22a. SIGNATURE: George Simons — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): George Simons

22d. ADDRESS: Memorial Hospital, Cumb., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-9-67

23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery

23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland

24. FUNERAL DIRECTOR: H. Lee Silcox — ADDRESS: 404 Decatur St., Cumb., Md.

25a. REC'D BY REGISTRAR DATE: JUN 9 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07483 **CERTIFICATE OF DEATH** 07453

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 2WKS.3DAYS

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 139 ELDER STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): MEMORIAL HOSPITAL

3. NAME OF DECEASED (Type or print): First CLARA — Middle VIRGINIA — Last BREIGHNER

4. DATE OF DEATH: Month JUNE — Day 4 — Year 19 67

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9-10-1898
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HWFE.
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (County & State, or foreign country): WESTERNPORT, MD.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLES SHEETZ
14. MOTHER'S MAIDEN NAME: MARIE PETERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): no
16. SOCIAL SECURITY NO.: 220-03-7515
17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Massive Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 hours.
DUE TO
Conditions, if ony, which gave rise to immediate couse (a), stoting the underlying couse lost.
(b): Arteriosclerotic Cardio-vascular Disease — years
(c): Chronic Rheumatic Heart Disease with block 3° — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept., 1954, to June, 1967, that (I) (~~saw~~) last saw the deceased alive on June 4, 1967, and that death occurred at 2:45 A.M. from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: June 4, 1967
22c. PHYSICIAN'S NAME (Type): DR. OVERTON HIMMELWRIGHT
22d. ADDRESS: 133 VIRGINIA AVENUE, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 7, 1967
23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
23d. LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR — ADDRESS: James F. Scarpelli, Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: JUN 9 1967
25b. REGISTRAR'S SIGNATURE: [signature] Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07484 — **CERTIFICATE OF DEATH** — 07460

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing 01-1
d. STREET ADDRESS: Hanekamp Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Erma — Middle: A. — Last: Brodie
4. DATE OF DEATH: Month: June — Day: 6 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/1/1917
9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Lonaconing, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Hutcheson
14. MOTHER'S MAIDEN NAME: Bessie DeVault

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Robert Brodie "Husband" — Address: Lonaconing, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute pulmonary congestion — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.
DUE TO (b): Intractable Congestive failure 4341 — 7 days
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4341

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Primary Carcinoma breast & Pulmonary metastases
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19 65, to June 6, 1967, that (I) (we) last saw the deceased alive on June 6 1967, and that death occurred at 12:30 AM, from causes and on the date stated above.

22a. SIGNATURE: L.R. Miles JR M.D. — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6.6.67
22c. PHYSICIAN'S NAME (Type): L.R. MILES, JR M.D.
22d. ADDRESS: LONACONING MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/8/67
23c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery
23d. LOCATION (City or Town) (County) (State): Moscow A. Md

24. FUNERAL DIRECTOR: George Eichhorn — ADDRESS: Lonaconing, Md.
25a. REC'D BY REGISTRAR DATE: JUN 7 1967
25b. REGISTRAR'S SIGNATURE: Orlando Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film 7330 7/15/67 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07485 07461

1 PLACE OF DEATH
a COUNTY: Allegany
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c LENGTH OF STAY IN 1b: DOA
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial HOspital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE: Pennsylvania b COUNTY: Bedford
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyndman
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Adam Middle: H. Last: Bruck
4 DATE OF DEATH: Month, Day, Year: June 30, 1967
5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: January 6, 1967 1875
9 AGE (In years last birthday): 92 yrs
IF UNDER 1 YEAR: Months, Days
IF UNDER 24 HRS: Hours, Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpnter
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Fairhope, Pa. RD#1
12 CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME: Conrad Bruck
14 MOTHER'S MAIDEN NAME: Margaret Frey Bruck
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16 SOCIAL SECURITY NO: 200-05-4172A
17 INFORMANT Address: Mrs. Anna Ruth Bruck, Hyndman, PA.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO (b): CORONARY SCLEROSIS — ---
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒☒ Inquiry ☒☒☒ and in my opinion death resulted from Natural cause ☒☒☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: June 30, 1967
Address (Street, city, town, or county): Cumberland, Md.

23a BURIAL CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: July 2, 1967
23c NAME OF CEMETERY OR CREMATORY: Hyndman Cemetery
23d LOCATION (City or Town) (County) (State): Hyndman, Bedford Co., Pa.
24 FUNERAL DIRECTOR: Harvey H. Ziegler
ADDRESS: Hyndman, Pa.
25a RECD BY REGISTRAR DATE: JUL 5 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07486 07462

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): McCoole
c. LENGTH OF STAY IN 1b: years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): McMullen Hwy

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): McCoole
d. STREET ADDRESS: McMullen Hwy
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Michele Middle: Last: Cicchetto

4. DATE OF DEATH: Month: June Day: 27, Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: 6 May 1887

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (County & State, or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Antonio Cicchetto

14. MOTHER'S MAIDEN NAME: Francesca Panteleo

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Daughter Address: McCoole, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY;
IMMEDIATE CAUSE (a): Coronary Thrombosis
DUE TO (b): Coronary Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Immediate 5 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1962, 19..., to 6/26/, 19 67 that (I) (we) last saw the deceased alive on Nov 19, and that death occurred at 9:50 A.M., P.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

22b. DATE SIGNED: 6/30/67

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. PHYSICIAN'S NAME (Type): Harry F. Coffman, M.D.

22d. ADDRESS: 537 S. Mineral St. Keyser, W.Va. 26726

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1 July 1967

23c. NAME OF CEMETERY OR CREMATORY: St. Thomas

23d. LOCATION (City, town or county) (State): Keyser, W. Va.

24 FUNERAL DIRECTOR'S SIGNATURE: [signature]

ADDRESS: Keyser, W. Va.

25a. REC'D BY REGISTRAR DATE: JUL 3 1967

25b. REGISTRAR'S SIGNATURE: [signature]

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07487 — 07463

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 38 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND (RURAL)
d. STREET ADDRESS: RT. #5, BOX 361-A, WINCHESTER ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle B. — Last COLEMAN
4. DATE OF DEATH: Month JUNE — Day 9 — Year 19 67
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-5-15
9. AGE (In years last birthday): 51 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LIFT TRUCK OPERATOR
10b. KIND OF BUSINESS OR INDUSTRY: CELANESE CORP.
11. BIRTHPLACE (County & State, or foreign country): MIDLAND, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JOSEPH A. COLEMAN
14. MOTHER'S MAIDEN NAME: NETTIE (BUSKIRK) COLEMAN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES — (If yes give war or dates of service): W W 2
16. SOCIAL SECURITY NO.: 214-07-5793
17. INFORMANT: HOSPITAL RECORD — Address: 906 SETON DRIVE CUMB., MD. 21502

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Perforations of Duodenum
DUE TO (b): Peritonitis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 10 da.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 1948, to 9 June, 1967, that (I) (we) last saw the deceased alive on 8 June 1967, and that death occurred at ____M, from the causes and on the date stated above.

22a. SIGNATURE: S. G. Weisman M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/12/67
22c. PHYSICIAN'S NAME (Type): DR. S. G. WEISMAN
22d. ADDRESS: 59 GREENE ST., CUMB., MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 12, 1967
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City, town or county) (State): Cumberland, Maryland

24. FUNERAL DIRECTOR: John J. Hafer, Jr.
ADDRESS: 230 Balto Ave. Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: JUN 14 1967
25b. REGISTRAR'S SIGNATURE: Charles Yeager

VR A15 (4) 20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07688 07464

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 4DAYS2½HRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 229 COLUMBIA STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HAZEL — Middle C. — Last COLLINS

4. DATE OF DEATH: Month JUNE — Day 18, — Year 19 67

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 4, 1913

9. AGE (In years last birthday): 53 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HWFE. Owner

10b. KIND OF BUSINESS OR INDUSTRY: Insurance Agency

11. BIRTHPLACE (County & State, or foreign country): ROMNEY, W. VA.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ALLEN C. CRITES

14. MOTHER'S MAIDEN NAME: ROSA F. SIRK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO: UNKNOWN

17. INFORMANT — Address: MEMORIAL HOSPTTAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line) for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Peritonitis due to perfor. Append.	4 – 7d.
DUE TO (b)	Chronic Uremia	3 – 4 yrs
DUE TO (c)	Chronic pyelonephritis	?? yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

ICD: 580.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute anuria, acidosis, azotemia.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 6-16, 1967 to 6-18, 1967, that (I) (we) last saw the deceased alive on 6-18 1967, and that death occurred at 10:25 P.M., from the causes and on the date stated above.

22a. SIGNATURE: A. J. Mirkin M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-20-67

22c. PHYSICIAN'S NAME (Type): DR. A.J. MIRKIN

22d. ADDRESS: 122 SO. CENTRE ST. CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: JUNE 21, 1967

23c. NAME OF CEMETERY OR CREMATORY: SUNSET MEMORIAL PARK

23d. LOCATION (City or Town) (County) (State): CUMBERLAND, MD.

24. FUNERAL DIRECTOR: BYRON KIGHT — ADDRESS: CUMBERLAND, MD.

25a. RECD BY REGISTRAR DATE: JUN 23 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the ... Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with ... State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07489 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 07465

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dawson
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Home Near Dawson

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dawson
d. STREET ADDRESS: Keyser Route 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert Middle: Edwin Last: Crumbaugh
4. DATE OF DEATH: Month: June Day: 14, Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 29, 1897
9. AGE (In years last birthday): 70 yrs. IF UNDER 1 YEAR: Months: 4 Days: 15 IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Telegraph Operator
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Frederick, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Grayson E. Crumbaugh
14. MOTHER'S MAIDEN NAME: Alice C. Riggs
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes WWI
16. SOCIAL SECURITY NO: 236-12-7252
17. INFORMANT: Address: Muriel B. Crumbaugh, (Wife)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b): Coronary Sclerosis — ----

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: June 14, 1967
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.
Address (Street, city, town, or county): Cumberland, Maryland (State)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-17-67
22c. NAME OF CEMETERY OR CREMATORY: Queens Point Cemetery
22d. LOCATION (City, town, or country): Keyser, W. Va.

23. FUNERAL DIRECTOR: Thomas Brock
ADDRESS: Keyser, W. Va.
24. REC'D BY REGISTRAR DATE: JUN 20 1967
24b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07490

CERTIFICATE OF DEATH

07466

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 13 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: MARYLAND
b. COUNTY: [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 14 QUEEN CITY PAVEMENT
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First CLARA — Middle G — Last DAVIS

4 DATE OF DEATH: Month JUNE — Day 18 — Year 1967

5 SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: MAY 23, 1917

9. AGE (In years last birthday): 50 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): OWNER

10b. KIND OF BUSINESS OR INDUSTRY: TAVERN

11. BIRTHPLACE (County & State or foreign country): ALLEGANY MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM KEMP

14. MOTHER'S MAIDEN NAME: ANNIE DEETZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO: 216 18 1498

17. INFORMANT: MEMORIAL HOSPITAL, Address MEMORIAL AVENUE CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute exacerbation of chronic
DUE TO (b): lymphocytic leukemia
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
2040
INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 1967 to 6-18, 1967 that (I) (we) last saw the deceased alive on 6-18 1967, and that death occurred at 4:10 AM, from causes and on the date stated above.

22a. SIGNATURE: William P James M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/21/67

22c. PHYSICIAN'S NAME (Type): DR. WM P JAMES

22d. ADDRESS: 441 NO CENTRE ST. CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: JUNE 21, 1967

23c. NAME OF CEMETERY OR CREMATORY: ST. PETER & PAUL CEM.

23d. LOCATION (City or Town) (County) (State): CUMBERLAND, MD.

24 FUNERAL DIRECTOR: BYRON KIGHT — ADDRESS: CUMBERLAND, MD.

25a. RECEIVED BY REGISTRAR DATE: JUN 23 1967

25b. REGISTRAR'S SIGNATURE: Florence Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07491. 07467

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH — a COUNTY: Allegany — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 21 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a STATE: Maryland — b COUNTY: Allegany
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d STREET ADDRESS: 722 Elm Street
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: William — Middle: G. — Last: Elliott
4 DATE OF DEATH: Month: June — Day: 27 — Year: 19 67

5 SEX	6 COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
Male	White	NEVER MARRIED ☒	Nov. 3, 1945	21 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Clerk	Clerk Bureau	Cumberland, Md.	USA

13 FATHER'S NAME: Joseph W. Elliott
14 MOTHER'S MAIDEN NAME: Myrtle V. Powell

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown)	(If yes give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT — Address
yes	1963-1967		Mrs. Myrtle Elliott, Cumberland, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Intracranial Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 20½ Hrs.
DUE TO (b): Fractured Skull — 20½ Hrs.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
8254

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Driver of auto involved in a crash
20c TIME OF INJURY Month, Day, Year, Hour o'm: 2:30 June 26 1967
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.): Rt. 220, 2 mi. north
20f (City or town) (County) (State): Cumberland, Alleg. Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D. M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: June 27, 1967
EXAMINER'S NAME (Type): Dr. Benedict Skitarelic, M.D.
Address (Street, city, town, or county): Rt.9 Cumberland

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	June 30, 1967	St. Mary's Cemetery	Cumberland, Md. Allegany

24 FUNERAL DIRECTOR — ADDRESS	25a RECD BY REGISTRAR — DATE	25b REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	JUN 30 1967	Charles Judge

VR A15ME (5) 6M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 of funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07492 07468

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 10 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 109 POLK STREET, CUMBERLAND, MD.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 109 POLK STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First William Middle Russell Last Elliott

4. DATE OF DEATH: Month JUNE Day 2 Year 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: OCT 8 1898
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED EMPLOYEE OF CELANESE CORP. OF AMERICA
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): BEDFORD CO. PA.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM J. ELLIOTT
14. MOTHER'S MAIDEN NAME: MAUDE E. (BOORE) ELLIOTT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 123-10-8988A
17. INFORMANT: RUTH P. (ZEMBOWER) ELLIOTT Address: RFD#3 BEDFORD PA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): CORONARY SCLEROSIS — "
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: June 2, 1967
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.
Address (Street, city, town, or county): Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 5 JUNE 67
23c. NAME OF CEMETERY OR CREMATORY: FELLOWSHIP UNION
23d. LOCATION (City, town or county) (State): CENTERVILLE, PENNSYLVANIA

24. FUNERAL DIRECTOR ADDRESS: H. LEE SILCOX 404 DECATUR STREET CUMBERLAND MARYLAND
25a. REC'D BY REGISTRAR DATE: JUN 6 1967
25b. REGISTRAR'S SIGNATURE: H. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07498 — 07469

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Savage Rural
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Savage Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary Lillian — Middle: — Last: Emerick

4. DATE OF DEATH: Month: June — Day: 20, — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: July 18, 1890

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lonaconing, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Loar

14. MOTHER'S MAIDEN NAME: Mary Fitzpatrick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 217-10-1059D

17. INFORMANT Address: Margaret Emerick, Mt. Savage, Md.. RD#1

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Coronary Sclerosis — Years

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 6/20/67

Address (Street, city, town, or county): Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: June 23, 1967

22c. NAME OF CEMETERY OR CREMATORY: St. Patrick's Cemetery

22d. LOCATION (City, town, or county) (State): Mt. Savage, Maryland

23. FUNERAL DIRECTOR: Harry R. Zeigler,

ADDRESS: Hyndman, Pa.

24a. REC'D BY REGISTRAR: JUN 23 1967

24b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07497

CERTIFICATE OF DEATH

07473

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 619 N. Centre St. Cumb. Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 619 N. Centre St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Emma — Middle: A. — Last: Geatz

4. DATE OF DEATH: Month: June — Day: 11 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: July 3, 1894

9. AGE (If years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward O'Neill

14. MOTHER'S MAIDEN NAME: Mary Ann Kean

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Joseph E. Geatz — Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction; Uremia — INTERVAL BETWEEN ONSET AND DEATH: 0 mo.

20 IX

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive Heart Disease; Thrombo Phlebitis — 14 yr

DUE TO (c): Obesity-severe; Gen. osteo-arthritis.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): None

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 5, 1967 to June 11, 1967, that (I) (we) last saw the deceased alive on 6/11 1967, and that death occurred at 6:25 PM from the causes and on the date stated above.

22a. SIGNATURE: Jamed P. Hallinan M.D.

M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/12/67

22c. PHYSICIAN'S NAME (Type): James P. Hallinan M.D.

22d. ADDRESS: 140 Bedford St. Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/17/67

23c. NAME OF CEMETERY OR CREMATORY: St. Patricks Cem.

23d. LOCATION (City, town or county) (State): Cumberland, Md.

24. FUNERAL DIRECTOR: Davis Mortuary Inc. — ADDRESS: Cumb. Md.

25a. REC'D BY REGISTRAR DATE: JUN 15 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M '67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07494

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07470

1 PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: D O A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Vale
d. STREET ADDRESS: 962 National Highway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Anna; Middle: Catherine; Last: Ferguson

4. DATE OF DEATH: Month: June; Day: 1; Year: 19 67

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 1/25/1902

9 AGE (In years last birthday): 65 yrs

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? U S A

13 FATHER'S NAME: Christopher Weires

14. MOTHER'S MAIDEN NAME: Elizabeth Steele

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16 SOCIAL SECURITY NO: 217-18-4283

17 INFORMANT Address: Mrs. James P. Walton, Route 5, Cumberland, Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b): Coronary Sclerosis — --
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town or county): Cumberland, Md.

22. DATE SIGNED: June 2, 1967

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 1/ 4/67

23c NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery

23d LOCATION (City or Town, County, State): Cumberland, Alleg Md

24 FUNERAL DIRECTOR: John J. Hafer, Jr.

ADDRESS: 230 Baltimore Ave. Cumberland Md

25a RECD BY REGISTRAR DATE: JUN 6 1967

25b REGISTRAR'S SIGNATURE: Charles Judge

1 3

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07495

CERTIFICATE OF DEATH

07471

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: ALLEGANY MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND c. LENGTH OF STAY IN 1b: 7 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL	d STREET ADDRESS: 2 G JANE FRAZIER VILLAGE e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: ROBERT	Middle: W	Last: FLEEK	4. DATE OF DEATH	Month: JUNE	Day: 6	Year: 19 67				
5 SEX: MALE	6. COLOR OR RACE: WHITE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: XXXXX 1-10-98	9 AGE (In years last birthday): 69 yrs	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min					

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MAINTANENCE WORKER	10b. KIND OF BUSINESS OR INDUSTRY: RAILROAD	11. BIRTHPLACE (County & State, or foreign country): W. VA.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME: ADAM FLEEK		14. MOTHER'S MAIDEN NAME: MARGARET CADWALTER	
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)	16. SOCIAL SECURITY NO: UNKNOWN	17 INFORMANT: MEMORIAL HOSPITAL Address: CUMBERLAND, MD.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): CARCINOMATOSIS & METASTESES
DUE TO: TO THE SKULL, BRAIN, PRIMARY
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): SITE CARCINOMA OF SCALP
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ARTERIOSCLEROTIC HEART DISEASE; Possible CARCINOMA OF LUNG
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f (City or Town) (County) (State)	

21. I certify that (I) (this hospital) attended the deceased from ____, 1964, to 6/6, 1967, that (I) (we) last saw the deceased alive on 6/6 1967, and that death occurred at 3:30 P M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.	ATTENDING PHYS. ☒	MED DIRECTOR ☐	STAFF PHYS. ☐	22b DATE SIGNED: 6/8/67
22c PHYSICIAN'S NAME (Type): DR. S. G. WEISMAN	22d ADDRESS: CUMBERLAND, MD.			

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b DATE THEREOF: JUNE 9, 1967	23c NAME OF CEMETERY OR CREMATORY: ECKHART CEMETERY	23d LOCATION (City or Town): ECKHART	(County) (State): MD.
24. FUNERAL DIRECTOR: BYRON KIGHT	ADDRESS: CUMBERLAND, MD.	25a. REC'D BY REGISTRAR DATE: JUN 12 1967	25b. REGISTRAR'S SIGNATURE: [signature] Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07496

CERTIFICATE OF DEATH

07472

1

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 7 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FLINTSTONE (Star Route)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARVEY — Middle LESLEY — Last FREY
4. DATE OF DEATH: Month JUNE — Day 13, — Year 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-20-1888
9. AGE (In years last birthday): 78 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Photo Engraver
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): COLORADO
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: DANIEL FREY
14. MOTHER'S MAIDEN NAME: AUGUSTA STONE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO: 064-01-9530
17. INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINOMATOSIS OF BONE MARROW AND BONES
DUE TO (b):
DUE TO (c): CARCINOMA OF PROSTATE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Heart Disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a m p m 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3 /67, 19 to June 13, 19 67, that (I) (we) last saw the deceased alive on June 13 1967, and that death occurred at 12:50 P.M. June 13, 19 67, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 6/15/67
22c. PHYSICIAN'S NAME (Type): DR. S. G. WEISMAN
22d. ADDRESS: 59 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/16/67
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland

24. FUNERAL DIRECTOR ADDRESS: H. Lee Silcox Cumberland, Maryland 21502
25a. RECD BY REGISTRAR DATE: JUN 19 1967
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07498

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07474

1 PLACE OF DEATH
a COUNTY: Allegany
MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellerslie Rural
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): P. O. Box #1

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland
b COUNTY: Allegany
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Ellerslie Rural
d STREET ADDRESS: P. O. Box #1
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First CHARLENE Middle SUE Last GIBBNER

4 DATE OF DEATH: Month June 22 Day Year 1967

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: April 16, 1967

9 AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months 2 Days 7; IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Cumberland, Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Ray Gibbner

14 MOTHER'S MAIDEN NAME: Mary Esther Benna

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown): No (If yes give war or dates of service):

16 SOCIAL SECURITY NO: None

17. INFORMANT: Charles R. Gibbner Address: Ellerslie, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): LOBAR PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: HOURS
DUE TO
(b): (STREPTOCOCCAL)
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
490.Y

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18):

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: JUNE 22, 1967

Address (Street, city, town, or county): Cumberland, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: June 23, 1967

23c NAME OF CEMETERY OR CREMATORY: Hyndman Cemetery

23d LOCATION (City or Town) (County) (State): Hyndman, Bedford Co., Pa.

24 FUNERAL DIRECTOR: Harvey A. Teagle

ADDRESS: Hyndman, Pa.

25a RECD BY REGISTRAR DATE: JUN 26 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07499 07475

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt. # 6 Cumberland,
d. STREET ADDRESS: Brant Rd. Cresaptown,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Walter — Last: Grant

4. DATE OF DEATH: Month: June — Day: 26, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 17, 1924

9. AGE (In years last birthday): 43 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Driver-Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Dairy

11. BIRTHPLACE (County & State, or foreign country): Beryl, W. Va.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Charles R. Grant

14. MOTHER'S MAIDEN NAME: Eva Burke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes, (If yes give war or dates of service): W. W. # 2

16. SOCIAL SECURITY NO.: 219-14-6368

17. INFORMANT — Address: Mrs. Pauline Grant, Rt. # 6 Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Cardiovascular Renal Disease — 10 yrs
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 19 5[illegible], to 6/26/[illegible] 19 67, that (I) (we) last saw the deceased alive on 6/25 19 67, and that death occurred at 2:20 A. M., from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/27/67

22c. PHYSICIAN'S NAME (Type): S G VIETSHAN MD

22d. ADDRESS: 59 Greene St Cumberland Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/28/67

23c. NAME OF CEMETERY OR CREMATORY: Eckhart Cemetery

23d. LOCATION (City, town or county) (State): Eckhart, Allegany, Maryland

24. FUNERAL DIRECTOR — ADDRESS: H. Wayne George Cumberland, Maryland

25a. RECD BY REGISTRAR DATE: JUN 29 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

* Error 5/26/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
10 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07500

CERTIFICATE OF DEATH

07476

1 PLACE OF DEATH
a COUNTY: Allegany — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c LENGTH OF STAY IN 1b: 8/6/1966
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Allegany County Infirmary

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland
b COUNTY: Allegany
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oldtown,
d. STREET ADDRESS: Route #4
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Virginia — Middle Marie — Last Hartley

4. DATE OF DEATH: Month June — Day 27, — Year 19 67

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 1/4/1898
9 AGE (In years last birthday): 69 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (County & State, or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13 FATHER'S NAME: John Buser
14. MOTHER'S MAIDEN NAME: Delcie Boggs

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 111-24-9396
17 INFORMANT: P.O.Box 599, Cumberland, Md. Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Chronic Arteriosclerosis with Starvation — INTERVAL BETWEEN ONSET AND DEATH: Approx. 3 mo.
DUE TO (b): Chr. Myocardial Insufficiency — Approx. 1 yr.
DUE TO (c): Chr. A.S.C.V.D. with Hypertension — Approx 10 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hem. A.S. Diabetes Mellitus - C.V.A. June '66
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 8/6/1966, 19___, to 6/27/1967 19___, that (I) (we) last saw the deceased alive on 6/27/1967 19___, and that death occurred at 8:25 P. M. E.S.T. from causes and on the date stated above

22a. SIGNATURE: John A Topper M.D.
ATTENDING PHYS. ☒ MED DIRECTOR ☒ STAFF PHYS. ☒
22b DATE SIGNED: 6/28/1967
22c PHYSICIAN'S NAME (Type): John A. Topper, M. D.
22d ADDRESS: Memorial Hospital, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 6/30/1967
23c NAME OF CEMETERY OR CREMATORY: Glendale Brethren Cem
23d. LOCATION (City or Town) (County) (State): Flintstone Allegany Md.

24. FUNERAL DIRECTOR: John J. Hafer, Jr.
ADDRESS: John J. Hafer, Jr., 230 Baltimore Ave., Cumberland Md
25a RECD BY REGISTRAR DATE: JUN 30 1967
25b REGISTRAR'S SIGNATURE: [illegible]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07501

CERTIFICATE OF DEATH

07477

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b: 42 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MINERS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
d. STREET ADDRESS: 55 CENTENNIAL STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EDGAR — Middle: L. — Last: HARVEY

4. DATE OF DEATH: Month: JUNE — Day: 29, — Year: 19 67

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: DEC. 12, 1893

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED FLORIST

10b. KIND OF BUSINESS OR INDUSTRY: OWN BUSINESS

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: EDWIN J. HARVEY

14. MOTHER'S MAIDEN NAME: CLARA EVANS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO: 218-30-2484

17. INFORMANT — Address: DANE HARVEY, 340 ALLEGANY ST., FROSTBURG, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Arteriosclerotic CVD. — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Chronic Heart Failure — 3 mos.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from AUG., 1966, to 29 JUNE 1967, that (I) (we) last saw the deceased alive on 29 JUNE 1967, and that death occurred at 11.15 M, from causes and on the date stated above.

22a. SIGNATURE: Martin Rothstein M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 6/30/67

22c. PHYSICIAN'S NAME (Type): MARTIN L. ROTHSTEIN M.D.

22d. ADDRESS: 48 BROADWAY - FROSTBURG, MD. 21532

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: JULY 1, 1967

23c. NAME OF CEMETERY OR CREMATORY: FBG. MEMORIAL PARK

23d. LOCATION (City or Town) (County) (State): FROSTBURG, MD.

24. FUNERAL DIRECTOR — ADDRESS: JOSEPH R. DURST, SR., FROSTBURG, MD.

25a. REC'D BY REGISTRAR — DATE: JUL 3 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1 2

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07502

CERTIFICATE OF DEATH

07475

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
c. LENGTH OF STAY IN 1b: 1 yr.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kyle Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
d. STREET ADDRESS: Green St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John J. Middle H Healy Last
4. DATE OF DEATH: Month June 8 Day Year 19 67

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 5, 1881
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Car Repairman
10b. KIND OF BUSINESS OR INDUSTRY: Rail Road
11. BIRTHPLACE (County & State, or foreign country): Piedmont, W.Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Dennis Healy
14. MOTHER'S MAIDEN NAME: Margaret Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 705-09-7072
17. INFORMANT: Mary Luteman Address: Morgantown, W.Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Coronary Insufficiency
DUE TO (c) Arteriosclerosis - generalized

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 1962, to June 8, 1962, that (I) (we) last saw the deceased alive on June 6 1967, and that death occurred at 7p M, from the causes and on the date stated above.

22a. SIGNATURE: L Miles M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6.9.67
22c. PHYSICIAN'S NAME (Type): L.R. MILES JR
22d. ADDRESS: LONACONING MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 12, 1967
23c. NAME OF CEMETERY OR CREMATORY: Kalbaugh Cem.
23d. LOCATION (City, town or county) (State): Elk Garden, W.Va.

24. FUNERAL DIRECTOR: E Boal ADDRESS: Westernport, Md.
25a. REC'D BY REGISTRAR DATE: JUN 12 1967
25b. REGISTRAR'S SIGNATURE: J Charles Jorgensen

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07503 — 07479

FOR STATE HEALTH DEPT. 1 M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN b: 50 YEARS

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 535 N. CENTRE ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA MEMORIAL HOSPITAL

3. NAME OF DECEASED (Type or print): First: SLOAN — Middle: D. — Last: HOADLEY

4. DATE OF DEATH: Month: JUNE — Day: 23 — Year: 19 67

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JULY 13, 1894
9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FREIGHT HANDLER
10b. KIND OF BUSINESS OR INDUSTRY: RAILROAD
11. BIRTHPLACE (State or foreign country): W. VA.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: DAVID HOADLEY
14. MOTHER'S MAIDEN NAME: EMMA SAYLOR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): WW 1
16. SOCIAL SECURITY NO: 214 05 9213
17. INFORMANT: MRS. FRANCES MYERS — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): CORONARY SCLEROSIS — ----
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D. — CUMBERLAND, MD. (City or town) (County) — JUNE 23,1967

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: JUNE 26,1967
23c. NAME OF CEMETERY OR CREMATORY: FROSTBURG MEMORIAL PARK
23d. LOCATION (City or Town) (County) (State): FROSTBURG, MD.

24. FUNERAL DIRECTOR: BYRON KIGHT — ADDRESS: CUMBERLAND, MD.
25a. REC'D BY REGISTRAR DATE: JUN 27 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15ME (5) 6M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07504 Item #9 Film #0389 4/20/67 PC 07430

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt#2 Cumberland
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rt#2 Hazen Road Cumberland Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt#2 Hazen Road Rural Cumberland
d. STREET ADDRESS: Box 808 Hazen Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Mary Middle: Amanda Last: Horchler

4. DATE OF DEATH: Month: June Day: 10 Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: Oct. 21, 1882

9. AGE (In years last birthday): 84 86 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frederick Horchler (D)

14. MOTHER'S MAIDEN NAME: Almira [illegible] Long (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: George W. Horchler Address: Cumberland Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Sclerosis
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: Hours: —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22. DATE SIGNED: June 12, 1967

Address (Street, city, town, or county): Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/13/67

23c. NAME OF CEMETERY OR CREMATORY: St. Peter & Paul Cem.
ADDRESS:

23d. LOCATION (City, town or county) (State): Cumberland Md.

24. FUNERAL DIRECTOR: Louis Stein Inc. Cumb. Md.

25a. REC'D BY REGISTRAR DATE: JUN 15 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Yaugh

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07505 — 07481

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 3/31/1965
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 637 Shriver Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: — Last: Kaplon
4. DATE OF DEATH: Month: June — Day: 22, — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10/1/1885
9. AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired: Office Mngr.,
10b. KIND OF BUSINESS OR INDUSTRY: Hersch Bros.
11. BIRTHPLACE (County & State or foreign country): Kouvne, Lithuania
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Abraham Kaplon
14. MOTHER'S MAIDEN NAME: Rebecca Arnstein

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 214-05-5680
17. INFORMANT: P.O.Box 599, Cumberland, Md. 21502 Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocarditis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Generalized Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Diabetes Mellitus

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/31/65, 19___, to 6/22/67, 19___, that (I) (we) last saw the deceased alive on 6/21/67 19___, and that death occurred at 5:10 A.M. from causes and on the date stated above.

22a. SIGNATURE: George M. Simons M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☒ STAFF PHYS ☒
22b. DATE SIGNED: 6/22/1967
22c. PHYSICIAN'S NAME (Type): George M. Simons, M. D.
22d. ADDRESS: Memorial Hospital, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/33/67
23c. NAME OF CEMETERY OR CREMATORY: East View Cem.
23d. LOCATION (City or Town) (County) (State): Cumberland Md

24. FUNERAL DIRECTOR: Louis Stein Inc. — ADDRESS: Cumb. Md.
25a. REC'D BY REGISTRAR — DATE: JUN 26 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07506

CERTIFICATE OF DEATH

07482

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 13 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 1005 BEDFORD ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDWARD — Middle Simpkins — Last KELLER

4. DATE OF DEATH: Month JUNE — Day 18 — Year 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-19-04

9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WATCHMAKER

10b. KIND OF BUSINESS OR INDUSTRY: JEWELRY

11. BIRTHPLACE (County & State, or foreign country): MARYLAND, ALLEGANY CTY.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HARRY KELLER

14. MOTHER'S MAIDEN NAME: EMMA APPEL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 214-05-5734

17. INFORMANT: HOSPITAL RECORDS — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma of
DUE TO (b): Pharynx with
DUE TO (c): metastasis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1 1/2 M

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 5, 19 67, to June 18, 19 67, that (I) (we) last saw the deceased alive on June 18, 19 67, and that death occurred at 1:15 A M, from the causes and on the date stated above.

22a. SIGNATURE: Wyand F. Doerner Jr M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6-19-67

22c. PHYSICIAN'S NAME (Type): DR. WYAND F. DOERNER, M.D.

22d. ADDRESS: 414 N. MECHANIC ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/21/67

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

23d. LOCATION (City, town or county) (State): Cumberland Allegany Maryland

24. FUNERAL DIRECTOR: H. Lee Silcox

ADDRESS: Cumberland, Maryland 21502

25a. REC'D BY REGISTRAR DATE: JUN 21 1967

25b. REGISTRAR'S SIGNATURE:

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07507 — 07483

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 9/21/1966
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Allegany County Infirmary

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 406 Fayette St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: William — Middle: Lawrence — Last: Keller
4 DATE OF DEATH: Month: June — Day: 29 — Year: 19 67

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 5/12/1880
9 AGE (In years last birthday): 87 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dentist
10b KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): West Virginia
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Keller
14 MOTHER'S MAIDEN NAME: Margaret Zimmerman

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16 SOCIAL SECURITY NO.:
17 INFORMANT: P.O. Box 599 Cumberland, Md. Address: Allegany County Infirmary

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Ileus - Mechanical — INTERVAL BETWEEN ONSET AND DEATH: several days
DUE TO (b): Bilateral Inguinal Hernias - — many years
DUE TO (c): Strangulated Inguinal Hernia, acute — approx. 3 hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): B.P. Hi Bladder neck obstruction Senile A.S. Cor Asclo
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II. of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9/21/1966 19___, to 6/29/1967 19___, that (I) (we) last saw the deceased alive on 6/29/1967 19___, and that death occurred at 6:40 P. M, from causes and on the date stated above.

22a SIGNATURE: John A Topper M.D. — ATTENDING PHYS ☒ — MED DIRECTOR ☒ — STAFF PHYS. ☒
22b DATE SIGNED: June 30, 1967
22c. PHYSICIAN'S NAME (Type): John A. Topper, M.D.
22d ADDRESS: Memorial Hospital, Cumberland, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 7/3/67
23c NAME OF CEMETERY OR CREMATORY: SS Peter + Paul Cem
23d LOCATION (City or Town) (County) (State): Cumberland Md

24 FUNERAL DIRECTOR: Lantz Stein Inc. — ADDRESS: Cumb. Md.
25a. REC'D BY REGISTRAR DATE: JUL 6 1967
25b REGISTRAR'S SIGNATURE:

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07503

CERTIFICATE OF DEATH

07484

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 22 HRS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   d. STREET ADDRESS: 8 WESTVIEW TERRACE
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ESTELLA — Middle: E. — Last: KELLEY

4. DATE OF DEATH: Month: 6-8-67 — Day — Year: 19

5. SEX: F

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-4-10

9. AGE (In years last birthday): 57 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BEAUTICIAN

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MILL CREEK, W.VA.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: LORENZO A. MERRITT

14. MOTHER'S MAIDEN NAME: MARTHA SHRADER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): X

16. SOCIAL SECURITY NO.: 217-10-4333

17. INFORMANT: HOSPITAL RECORD — Address: CUMBERLAND MD 900 SETON DRIVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ACUTE ANTERIOR MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): DIABETES MELLITUS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from DEC, 19 64 to 6 - 8, 19 67, that (I) (we) last saw the deceased alive on 6 - 8 19 67, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE: Dr. Glick — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6 - 9 - 67

22c. PHYSICIAN'S NAME (Type): DR. M. GLICK

22d. ADDRESS: 126 N. SMALLWOOD ST., CUMB., MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/10/67

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

23d. LOCATION (City, town or county) (State): Cumberland Allegany Maryland

24. FUNERAL DIRECTOR — ADDRESS: H. Lee Silcox Cumberland Maryland 21502

25a. REC'D BY REGISTRAR DATE: JUN 14 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07509 07485

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Than please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 426 FURNACE ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNA Middle C. Last KIRBY

4. DATE OF DEATH: Month JUNE Day 20 Year 19 67

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5-28-91

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ___

11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN M. RANK

14. MOTHER'S MAIDEN NAME: ELIZABETH HOWELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give war or dates of service): ___

16. SOCIAL SECURITY NO.: 218-38-0408

17. INFORMANT Address: HOSPITAL RECORDS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY HEART DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 5 YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): ___
DUE TO (c): ___

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5 - 6, 1956, to 6 - 20, 1967, that (I) (we) last saw the deceased alive on 6 - 20 1967, and that death occurred at 2 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Ralph W Ballin M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-20-67

22c. PHYSICIAN'S NAME (Type): RALPH W, BALLIN, M.D.

22d. ADDRESS: 62 GREENE ST CUMBERLAND, MD.21502

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/23/67

23c. NAME OF CEMETERY OR CREMATORY: St Lukes Cem.

23d. LOCATION (City, town or county) (State): Cumberland Md.

24. FUNERAL DIRECTOR: Louis Stein Inc. STEIN'S FUNERAL HOME ADDRESS: Cumb. Md. 117 FREDERICK ST.

25a. REC'D BY REGISTRAR DATE: JUN 23 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07510

CERTIFICATE OF DEATH

07486

1 PLACE OF DEATH
a COUNTY: Allegany — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 2/22/1967

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
d. STREET ADDRESS: Hanekamp Street
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Allegany County Infirmary

3 NAME OF DECEASED (Type or print): First Galen Middle C. Last Laird
4 DATE OF DEATH: Month June Day 15, Year 1967
5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 1/15/1901
9 AGE (In years last birthday): 66 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (County & State, or foreign country): Lonaconing, Maryland
12 CITIZEN OF WHAT COUNTRY? U. S. A.
13 FATHER'S NAME: Clarkson Laird
14. MOTHER'S MAIDEN NAME: Mary Mason
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO
17 INFORMANT: P.O.Box 599, Cumberland, Md. Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute myocardial Insufficiency. — INTERVAL BETWEEN ONSET AND DEATH: Approx. 4 days
DUE TO
(b): Chr. Emphysema. — Approx. 15 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Hypertensive C.V.D. — Approx.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Myocardial Insufficiency.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/22/1967, 19___, to 6/15/1967, 19___, that (I) (we) last saw the deceased alive on 6/14/1967 19___, and that death occurred at 8:55 A. M. from causes and on the date stated above.

22a SIGNATURE: John A Topper — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☒ STAFF PHYS. ☒
22b. DATE SIGNED: 6/15/1967
22c PHYSICIAN'S NAME (Type): John A. Topper, M. D.
22d. ADDRESS: Memorial Hospital, or home, Hyndman, Pennsylvania

23a BURIAL, CREMATION, REMOVAL (Specify): 6/18/1967
23b DATE THEREOF: Burial
23c NAME OF CEMETERY OR CREMATORY: Memorial Park
23d LOCATION (City or Town) (County) (State): Frostburg, Md.

24 FUNERAL DIRECTOR: George Eichhorn
ADDRESS: Lonaconing, Md.
25a. RECD BY REGISTRAR DATE: JUN 16 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07511

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07487

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Corriganville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Jane — Last: Lepley

4. DATE OF DEATH: Month: June — Day: 8, — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 13, 1909

9. AGE (In years last birthday): 58 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Fairhope, PA. RD#1

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Oliver Emerick

14. MOTHER'S MAIDEN NAME: Minnie Rebecca Clites

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO: 217-14-4210

17. INFORMANT: Louis Lepley, Address: Corriganville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b): Coronary Sclerosis — ----
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Cumberland, Md.

22. DATE SIGNED: June 7, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 11, 1967
23c. NAME OF CEMETERY OR CREMATORY: Comps Cemetery
23d. LOCATION (City or Town) (County) (State): Hyndman Somerset Co., Pa.

24. FUNERAL DIRECTOR: Harvey H. Feagler
ADDRESS: Hyndman, Pa.

25a. RECD. BY REGISTRAR DATE: JUN 14 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

Dr. Wilson

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07518

CERTIFICATE OF DEATH

07483

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page (1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
c. LENGTH OF STAY IN 1b: 60 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 105 First Street.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
d. STREET ADDRESS: 105 First Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Norman — Middle: Gilbert — Last: Linkswiler

4. DATE OF DEATH: Month: June — Day: 17, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 5, 1907

9. AGE (In years last birthday): 60 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal

11. BIRTHPLACE (County & State, or foreign country): Westernport, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James D. Linkswiler

14. MOTHER'S MAIDEN NAME: Maggie Mae Reeves.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO: 216-07-9635

17. INFORMANT — Address: Mrs. Norman Linkswiler, 105 First St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 5 years
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Silicosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 10, 1963, to June 17, 1967, that (I) (we) last saw the deceased alive on June 17 1967, and that death occurred at 9:20 P.M. from causes and on the date stated above

22a. SIGNATURE: Paul R. Wilson M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: June 19, 1967

22c. PHYSICIAN'S NAME (Type): Paul R. Wilson M.D.

22d. ADDRESS: Piedmont, W. Va.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 20, 1967

23c. NAME OF CEMETERY OR CREMATORY: Philos Cemetery

23d. LOCATION (City or Town) (County) (State): Westernport, Allegany, Md.

24. FUNERAL DIRECTOR: E.S. Boal — ADDRESS: Westernport, Md.

25a. REC'D BY REGISTRAR DATE: JUN 20 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

- 1 -

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07513

CERTIFICATE OF DEATH

07489

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Midland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress):

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outs.de corporate limits, write RURAL and give nearest town): Midland
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Salem — Middle: — Last: Loar

4. DATE OF DEATH: Month: June — Day: 16 — Year: 19 67

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/2/1900

9. AGE (In years last birthday): 67 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mine

11 BIRTHPLACE (County & State or foreign country): Vale Summitt, Md

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Noah Loar

14. MOTHER'S MAIDEN NAME: Violet Morton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes give war or dates of service): W.WAR 1

16 SOCIAL SECURITY NO: 214-01-6661

17. INFORMANT: Mrs. Viola Loar "Wife" — Address: Midland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a) (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Coronary Occlusion
DUE TO (b): Coronary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 3 years
DUE TO (c): Arteriosclerosis — years
Conditions, if ony, which gave rise to immediate couse (a), stating the underlying couse last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19 60 to June 16 19 67 that (I) (we) last saw the deceased alive an June 8 1967, and that death occurred at _____ M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 6.16.67

22c. PHYSICIAN'S NAME (Type): L.R. MILES, JR

22d. ADDRESS: LONACONING MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 6/19/1967

23c NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park

23d LOCATION (City or Town) (County) (State): Frostburg A. Md

24. FUNERAL DIRECTOR: George Eichhorn — ADDRESS: Lonaconing, Md.

25a. REC'D BY REGISTRAR DATE: JUN 19 1967

25b. REGISTRAR'S SIGNATURE: [signature] Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the coroner, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07514

CERTIFICATE OF DEATH

07490

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH — a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
   c. LENGTH OF STAY IN 1b: 2 WEEKS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MINERS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) — a. STATE: MARYLAND — b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
   d. STREET ADDRESS: 224 EAST MAIN STREET
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: RUTH — Middle: BEATRICE — Last: LOCKARD

4. DATE OF DEATH: Month: JUNE — Day: 26, — Year: 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: JUNE 6, 1907

9. AGE (In years last birthday): 60 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): ALLEGANY ZIHLMAN, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HENRY STEELE

14. MOTHER'S MAIDEN NAME: DAISY MUSETTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: MR. GEORGE LOCKARD, 224 E. MAIN STREET FROSTBURG, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Chronic glomerular nephritis	Months
DUE TO (b)	Cardiovascular disease	Years
DUE TO (c)	Chronic chest disease	Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May, 1967 to June 26, 1967 that (I) (we) last saw the deceased alive on June 26 1967, and that death occurred at 12:30 P.M., from causes and on the date stated above

22a. SIGNATURE: John B. Davis, M.D. — ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 6/27/67

22c. PHYSICIAN'S NAME (Type): JOHN B. DAVIS, M.D.

22d. ADDRESS: 2 BROADWAY, FROSTBURG, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: JUNE 29, 1967

23c. NAME OF CEMETERY OR CREMATORY: FROSTBURG MEM. PARK

23d. LOCATION (City or Town) (County) (State): FROSTBURG, MARYLAND

24. FUNERAL DIRECTOR: Marilou M. Sowers — HAFER-SOWERS FUNERAL HOME — ADDRESS: MARILOU M. SOWERS 60 W. MAIN, FROSTBURG

25. RECD BY REGISTRAR DATE: JUL 6 1967

25b. REGISTRAR'S SIGNATURE: Jessie Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07515

CERTIFICATE OF DEATH

07491

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CORRIGANVILLE
c. LENGTH OF STAY IN 1b: 17 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CORRIGANVILLE
d. STREET ADDRESS: BOX 173, Park Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: GUY Middle: Earl. Last: MARTIN

4. DATE OF DEATH: Month: JUNE Day: 19 Year: 19 67

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-22-39

9. AGE (In years last birthday): 28 yrs. IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian,

10b. KIND OF BUSINESS OR INDUSTRY: Fraternal Organztn.

11. BIRTHPLACE (County & State, or foreign country): ALLEGANY CTY, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GUY MARTIN

14. MOTHER'S MAIDEN NAME: Esther Dickel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 212-38-6538

17. INFORMANT: Mrs. Dorothy M. Martin Address: HOSPITAL RECORDS Box 173 Corriganville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 1 month

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Ewings Sarcoma - K. Rib — 18 mos.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8 Jun., 1967, to 19 June, 1967, that (I) (we) last saw the deceased alive on 18 June 1967, and that death occurred at 6:45 P.M, from the causes and on the date stated above.

22a. SIGNATURE: James Stegmaier M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 19 June 67

22c. PHYSICIAN'S NAME (Type): DR. JAMES G. STEGMAIER

22d. ADDRESS: 122 S. CENTRE STREET, CUMBERLAND, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/21/67

23c. NAME OF CEMETERY OR CREMATORY: Restlawn Mem. Gardens

23d. LOCATION (City, town or county) (State): Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS: H. Wayne George Cumberland, Maryland

25a. REC'D BY REGISTRAR DATE: JUN 23 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4) 20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07516

CERTIFICATE OF DEATH

07432

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Moscow
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HAZEL — Middle — Last MATTHEWS

4. DATE OF DEATH: Month 6/17/1967 Day Year 19

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6/8/1908

9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Louis Smith

14. MOTHER'S MAIDEN NAME: Rose Bradford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Edward P. Matthews, Moscow, MD. (Husband)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Coronary Sclerois — 4 hours
DUE TO
(c): Arteriosclerotic Heart Disease — 10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from JUNE 16, 1967, to JUNE 17, 1967, that (I) (we) last saw the deceased alive on JUNE 17 1967, and that death occurred at 2:55 A.M., from causes and on the date stated above.

22a. SIGNATURE: G Paige Strong — M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: June 17, 1967
22c. PHYSICIAN'S NAME (Type): A. Pagie Strong
22d. ADDRESS: 167 E. Main St - Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/19/1967
23c. NAME OF CEMETERY OR CREMATORY: Laruel Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Moscow, Md.

24. FUNERAL DIRECTOR — ADDRESS: George Eichhorn Lonaconing, Md.
25a. REC'D BY REGISTRAR: JUN 20 1967
25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P 3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07517

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07493

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 13 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 418 Oldtown Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 418 Oldtown Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Elizabeth Middle Gillin Last McCartneysmith
4. DATE OF DEATH: Month June Day 25 Year 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 16, 1891
9. AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Musician & Evangelist
10b. KIND OF BUSINESS OR INDUSTRY: Missionary
11. BIRTHPLACE (State or foreign country): Waterloo, Iowa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Franklin H. McCartney
14. MOTHER'S MAIDEN NAME: Frances J. Gillin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Eugene Abe
Address: 502 Montreal Avenue, Cumb., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO (b): CORONARY SCLEROSIS — --
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: June 25, 1967
Address (Street, city, town, or county): Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 28, 1967
23c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Park
23d. LOCATION (City or Town) (County) (State): Near Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR: John J. Hafer
ADDRESS: John J. Hafer, Jr.-230 Balto. Ave., Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: JUN 28 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and if any event within 72 hours after death.

VR AISME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07518 — **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** — 07494

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b: D O A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MINERS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
d. STREET ADDRESS: RT. 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARTHA — Middle ELIEN — Last McKENZIE

4. DATE OF DEATH: Month JUNE — Day 8, — Year 19 67

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEB. 24, 1904

9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WORK

10b. KIND OF BUSINESS OR INDUSTRY: PRIVATE HOMES

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE CATON

14. MOTHER'S MAIDEN NAME: NANCY ALBRIGHT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 216-22-5441

17. INFORMANT: CLARENCE McKENZIE, RT. 2, BOX 462, FROSTBURG, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

4301

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Sclerosis
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M. D.

Address (Street, city, town, or county): RD 9, CUMBERLAND, MD

22. DATE SIGNED: 6/9/67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: JUNE 12 '67

23c. NAME OF CEMETERY OR CREMATORY: JOHNSON CEMETERY

23d. LOCATION (City, town or county) (State): GARRETT COUNTY, MARYLAND

24. FUNERAL DIRECTOR — ADDRESS: JOSEPH R. DURST, SR., FROSTBURG, MD.

25a. REC'D BY REGISTRAR DATE: JUN 14 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07513 Item #12 Film #1390 5/23/67 pc

CERTIFICATE OF DEATH

07495

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 15 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 406½ FURNACE ST., CUMB., MD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: PETER — Middle: C. — Last: MECONI

4. DATE OF DEATH: Month: JUNE — Day: 14 — Year: 19 67

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-14-1900

9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STORE OWNER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): LUCCA, ITALY

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ANASTASIA

14. MOTHER'S MAIDEN NAME: FRANCESA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 214-32-2909

17. INFORMANT: HOSPITAL RECORD — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): UREMIC POISONING — INTERVAL BETWEEN ONSET AND DEATH: 2 WKS

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): GASTROINTESTINAL HEMMORHAGE — 2 WKS
DUE TO (c): SEVERE ANEMIA WITH THROMBOCYTOPENIA — 4 WKS.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CHRONIC LIVER DISEASE-ARTERIOSCLEROTIC HEART DISEASE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): NONE

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from MAY 30, 19 67 to JUNE 14, 19 67, that (I) (we) last saw the deceased alive on JUNE 14, 19 67, and that death occurred at 5.05 AM, from the causes and on the date stated above.

22a. SIGNATURE: James P. Hallinan MD — M.O. ATTENDING PHYS. # ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-14-67

22c. PHYSICIAN'S NAME (Type): JAMES P. HALLINAN, M.D.

22d. ADDRESS: 140 BEDFORD ST., CUMB., MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/16/67

23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cem

23d. LOCATION (City, town or county) (State): Cumberland MD

24. FUNERAL DIRECTOR: James Stein Inc. — ADDRESS: Cumb. MD

25a. REC'D BY REGISTRAR DATE: JUN 19 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07520

CERTIFICATE OF DEATH

07496

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-(4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Allegan, MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg,
c. LENGTH OF STAY IN (b): 4 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miner's Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Allegany
b. COUNTY: Md
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Savage
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Cora Middle Belle Last Metz

4. DATE OF DEATH: Month June Day 16, Year 19 67

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 9, 1890
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Scranton, Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Benjamin Sweitzer
14. MOTHER'S MAIDEN NAME: Isabelle Scuco

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: --
17. INFORMANT: Howard [illegible] Address: [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): due to coronary sclerosis — 5 days
DUE TO
(c): Hypertensive cardiovascular disease — 10 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 12, 19 67, to June 16, 19 67, that (I) (we) last saw the deceased alive on June 15 19 67, and that death occurred at 3:15 AM, from causes and on the date stated above.

22a. SIGNATURE: A Paige Strong
M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: June 16, 1967
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/20/67
23c. NAME OF CEMETERY OR CREMATORY: New German [illegible] Cumberland, Md.
23d. LOCATION (City or Town) (County) (State)

24. FUNERAL DIRECTOR: Ruth Neuman
ADDRESS: Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: JUN 21 1967
25b. REGISTRAR'S SIGNATURE: Richard Long

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07521

CERTIFICATE OF DEATH

07497

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 2 HRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
d. STREET ADDRESS: 13 LAING AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: BABY BOY — Middle: — Last: MILLER

4. DATE OF DEATH: Month: 6-5- — Day: — Year: 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-5-67

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: EUGENE MILLER

14. MOTHER'S MAIDEN NAME: LOIS J. CHANEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO: NONE

17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): ANOXIA
DUE TO (b): PREMATURITY
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred 9:30 A.M., from causes and on the date stated above

22a. SIGNATURE: Robert D. Brodell M.D. — ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): DR. ROBERT D. BRODELL

22d. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: JUNE 6, 1967

23c. NAME OF CEMETERY OR CREMATORY: PLEASANT VALLEY

23d. LOCATION (City or Town) (County) (State): LOCKLYNN, MD-GARRETT

24. FUNERAL DIRECTOR: JAMES FRANCIS SCARPELLI — ADDRESS: CUMBERLAND, MD.

25a. REC'D BY REGISTRAR — DATE: JUN 9 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07522

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07498

1 PLACE OF DEATH
a COUNTY: Allegany — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c LENGTH OF STAY IN 1b: DOA
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE: Maryland — b. COUNTY: Allegany
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: Polk Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Frances — Middle: S. — Last: Mongold

4 DATE OF DEATH: Month: June — Day: 8 — Year: 19 67

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: June 6, 1906

9 AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress

10b KIND OF BUSINESS OR INDUSTRY: Restaurant

11 BIRTHPLACE (State or foreign country): Hartford, Conn

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ?

14 MOTHER'S MAIDEN NAME: ?

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes give war or dates of service): War II

16 SOCIAL SECURITY NO:

17 INFORMANT — Address: Mr. Cleo Mongold, Cumberland, Md. Husband

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b): Coronary Sclerosis — Sudden: --
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year, Hour o'm. a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): Cumberland, Md.

22. DATE SIGNED: June 8, 1967

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: June 13, 1967

23c NAME OF CEMETERY OR CREMATORY: Winchester National Cem.

23d LOCATION (City or Town) (County) (State): Winchester, Va.

24 FUNERAL DIRECTOR — ADDRESS: James F. Scarpelli, Cumberland, Md.

25c RECD BY REGISTRAR DATE: JUN 14 1967

25b REGISTRAR'S SIGNATURE: Charles Yeager

1 3

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07523

CERTIFICATE OF DEATH

07499

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH a. COUNTY: ALLEGANY — MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND c LENGTH OF STAY IN 1b: 5 DAYS d NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): MEMORIAL HOSPITAL	2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: ALLEGANY c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND d STREET ADDRESS: 121 PENNSYLVANIA AVE. e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
JOHN	E.	MORRIS	JUNE	4	1967

5 SEX	6. COLOR OR RACE	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
MALE	WHITE		8-10-1905	61 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country)	12 CITIZEN OF WHAT COUNTRY?
RETIRED	Textile & Cab Co.	HYNDMAN, PA.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOHN MORRIS	MARTHA DEVORE

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16 SOCIAL SECURITY NO.	17. INFORMANT Address
no		MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): [illegible]
DUE TO (b): Congestive heart failure
DUE TO (c): Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or Town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from _____, 19 65, to 6/4/, 19 67, that (I) (we) last saw the deceased alive on 6/4 19 67, and that death occurred at 7:05 P.M. from causes and on the date stated above

22a SIGNATURE	ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐	22b DATE SIGNED
[signature] M.D		6/5/67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
DR. WEISMAN	59 GREENE STREET, CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	June 7, 1967	St. Patrick's Cemetery	Cumberland Md. Allegany

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	JUN 9 1967	J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07524

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07560

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Corriganville
c. LENGTH OF STAY IN 1b: Most of Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Rt. 1 Hyndman

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Md. — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Corriganville, Md.
d. STREET ADDRESS: Rt. 1 Hyndman, Pa.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Sylvia — Middle: A. — Last: Myers

4 DATE OF DEATH: Month: June — Day: 16 — Year: 19 67

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: Oct. 16, 1907

9 AGE (In years last birthday): 59 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Pa.

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Peter Bowman

14. MOTHER'S MAIDEN NAME: Alice (Bird)

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: None

17. INFORMANT: Gordon Bowman — Address: R. D. #2 Glen Rock, Pa.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO
(b): CORONARY SCLEROSIS
DUE TO
(c):
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month Day Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm factory, street, office bldg. etc.)

20f (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: June 16, 1967

Address (Street, city, town, or county): Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jun. 18, 1967

23c. NAME OF CEMETERY OR CREMATORY: Mt. Savage Meth. Cemetery

23d. LOCATION (City or Town) (County) (State): Mt. Savage Allegany Md.

24 FUNERAL DIRECTOR: William G. Kight — ADDRESS: Cumberland, Md.

25a. LOCAL REGISTRAR — DATE: JUN 20 1967

25b. REGISTRAR'S SIGNATURE

VR A15ME (5)
6M 1/66

1-3

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07525 -

CERTIFICATE OF DEATH

07501

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Allegany
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN To
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
d. STREET ADDRESS: Dudley Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JESSIE Middle S. Last NEAT

4. DATE OF DEATH: Month 6/14/1967 Day Year 19

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10/27/1893

9. AGE (In years last birthday): 73 yrs

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Lonaconing, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John F. Steele

14. MOTHER'S MAIDEN NAME: Frances Emerson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Irvin Neat Address: Lonaconing, Md. (S&N)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Ischemia
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Insufficiency
DUE TO (c): Arteriosclerosis generalized

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19 58 to June 14, 19 67, that (I) (we) last saw the deceased alive on June 14 1967, and that death occurred at 9 P M, from causes and on the date stated above.

22a. SIGNATURE: L R Miles M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6.15.67

22c. PHYSICIAN'S NAME (Type): L R MILES JR M.D.

22d. ADDRESS: LONACONING MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/17/1967

23c. NAME OF CEMETERY OR CREMATORY: Memorial Park

23d. LOCATION (City or Town) (County) (State): Frostburg, Md.

24. FUNERAL DIRECTOR: George Eichhorn

ADDRESS: Lonaconing, Md.

25a. REC'D BY REGISTRAR DATE: JUN 16 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07526

CERTIFICATE OF DEATH

07502

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLNAD
c. LENGTH OF STAY IN 1b: 2 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 200 SETON DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FAYE Middle E. Last OLMSTEAD

4. DATE OF DEATH: Month 6 Day 2 Year 19 67

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 03-24-95

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): VINLAND, KANSAS

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES W. WILLIAMS

14. MOTHER'S MAIDEN NAME: EMMA (DEAY)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 511-30-6685

17. INFORMANT: HOSPITAL ADMISSION
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-26, 1967, to 6-2, 1967, that (I) (we) last saw the deceased alive on 6-2 19 67, and that death occurred at 7 P M, from the causes and on the date stated above.

22a. SIGNATURE: [signature]
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-2-67

22c. PHYSICIAN'S NAME (Type): L. M. Golick

22d. ADDRESS: 12 GN. SMALLWOOD CUMBERLAND MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/5/67

23c. NAME OF CEMETERY OR CREMATORY: Deay Cemetery

23d. LOCATION (City, town or county) (State): Vinland Kansas

24. FUNERAL DIRECTOR ADDRESS: H. Lee Silcox 404 Decatur St Cumberland, Md

25a. REC'D BY REGISTRAR DATE: JUN 6 1967

25b. REGISTRAR'S SIGNATURE: [signature]

VR A15 (4)
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #8 & 9 Film #3590 5/29/67 pc

07527

CERTIFICATE OF DEATH

07503

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH a. COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: Allegany
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Westernport Rt. 1 c LENGTH OF STAY IN 1b: 25 yrs.	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Westernport Route 1
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 1 Westernport	d STREET ADDRESS: Route 1 Westernport e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print)	First: Alice	Middle: Virginia	Last: Paugh	4 DATE OF DEATH	Month: June	Day: 13	Year: 1967	
5 SEX: Female	6 COLOR OR RACE: White	7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8 DATE OF BIRTH: Sept 14, 1897	9. AGE (In years last birthday): 69 yrs	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic	10b KIND OF BUSINESS OR INDUSTRY: Own Home	11 BIRTHPLACE (County & State, or foreign country): Maryland	12 CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Joseph Tasker		14. MOTHER'S MAIDEN NAME: Mary Bane	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16 SOCIAL SECURITY NO	17. INFORMANT: Mrs Ray Mayhew	Address: Route 1, Westernport

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): Carcinoma of the cervix with metastasis — INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____M, from causes and on the date stated above.

22a. SIGNATURE: Phillip E Staggers M.D.	ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED: 6/14/67	
22c. PHYSICIAN'S NAME (Type): Phillip Staggers, M.D.	22d. ADDRESS: Keyser, W.Va.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE THEREOF: June 16, 1967	23c. NAME OF CEMETERY OR CREMATORY: Philos Cem.	23d LOCATION (City or Town): Westernport	(County) (State): Md.
24. FUNERAL DIRECTOR: E.D. Beal	ADDRESS: Westernport, Md.	25. ACCEPTED BY REGISTRAR DATE: JUN 15 1967	26. REGISTRAR'S SIGNATURE: Charles Judge	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07528

CERTIFICATE OF DEATH

07504

1 PLACE OF DEATH a. COUNTY: ALLEGANY — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND

c. LENGTH OF STAY IN 1b: 6 DAYS

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: MARYLAND b. COUNTY: ALLEGANY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND

d. STREET ADDRESS: 113 UTAH AVENUE

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First CHARLES Middle E. Last PFEIFFER

4 DATE OF DEATH: Month JUNE Day 5 Year 1967

5 SEX: MALE

6 COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: 9-13-77

9. AGE (In years last birthday): 89 yrs

IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS: Hours ____ Min. ____

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Celanese (Ret)

10b KIND OF BUSINESS OR INDUSTRY: Textile

11. BIRTHPLACE (County & State, or foreign country): PENNSYLVANIA

12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: CHRISTOPHER PFEIFFER

14 MOTHER'S MAIDEN NAME: CHRISTINA WHITE

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17 INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO (b): Myocardial Infarction — 2 mos.

DUE TO (c): Arteriosclerosis — 10 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4211

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER):

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.):

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f (City or town) (County) (State)

21 I **certify** that (I) (this hospital) attended the deceased from June, 1965 to June 5, 1967, that (I) (we) last saw the deceased alive on ____ 19____, and that death occurred at 3:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Clay E. Durrett M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: June 6, 1967

22c PHYSICIAN'S NAME (Type): DR. CLAY E. DURRETT

22d ADDRESS: CUMBERLAND, MD

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 6/8/67

23c NAME OF CEMETERY OR CREMATORY: Palo Alto Cemetery

23d LOCATION (City or Town) (County) (State): Palo Alto Penna.

24 FUNERAL DIRECTOR ADDRESS: Philip B. Wendt 121 Mem. Ave., Cumb., Md.

25a REC'D BY REGISTRAR DATE: JUN 9 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
MO M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07529

CERTIFICATE OF DEATH

67505

1 PLACE OF DEATH
a. COUNTY ALLEGANY
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
c LENGTH OF STAY IN 1b 8 DAYS
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b COUNTY ALLEGANY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
d STREET ADDRESS 241 VALLEY ST.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First GRACE Middle MAY Last PLUMMER
4. DATE OF DEATH Month JUNE Day 26 Year 19 67
5 SEX FEMALE
6 COLOR OR RACE WHITE
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH 3-3-1904 XXXXXXXXXXXX
9 AGE (In years last birthday) 63 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b KIND OF BUSINESS OR INDUSTRY Own Home
11 BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA
12 CITIZEN OF WHAT COUNTRY U. S. A.
13. FATHER'S NAME JOHN MANUELS
14 MOTHER'S MAIDEN NAME CHARLOTTE KLINE
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 8 days
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-19-67 to 6-26-67 that (I) (we) last saw the deceased alive on 6-26-1967, and that death occurred at 8:05 P.M., from causes and on the date stated above.

22a SIGNATURE Wyand F. Doerner M.D
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED 6-29-67
22c PHYSICIAN'S NAME (Type) DR. WYAND F. DOERNER JR
22d ADDRESS CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b DATE THEREOF 6-29-1967
23c NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
23d LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany

24 FUNERAL DIRECTOR ADDRESS James F. Scarpelli, Cumberland, Md.
25a. REC'D BY REGISTRAR DATE JUL 3 1967
25b REGISTRAR'S SIGNATURE C. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07530 — 07506

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route #6

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: Route #6
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Zelma — Middle: Mae — Last: Psimer
4. DATE OF DEATH: Month: June — Day: 20th, — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 24, 1929
9. AGE (In years last birthday): 38 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Keyser, W.Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harrold R. Harrison
14. MOTHER'S MAIDEN NAME: Delia Roberts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT: Fred H. Psimer — Address: RF #6 Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CORONARY OCCLUSION, RIGHT — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO (b): CORONARY THROMBOSIS — 〃
DUE TO (c):
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MED CAL EXAMINER ☒
Address (Street, city, town, or coun: CUMBERLAND, MARYLAND
22. DATE SIGNED: June 20, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 23, 1967
23c. NAME OF CEMETERY OR CREMATORY: Rest Lawn Memo. Garden
23d. LOCATION (City or Town) (County) (State): LaVale, Md

24. FUNERAL DIRECTOR: Allen M. Rotruck — ADDRESS: Keyser, W.Va.
25a. REC'D BY REGISTRAR — DATE: JUN 22 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07531 — 07507

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: NONE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARDING — Middle RICHARDSON — Last

4. DATE OF DEATH: Month JUNE — Day 8 — Year 19 67

5. SEX: MALE
6. COLOR OR RACE: NEGRO
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: UNKNOWN
9. AGE (In years last birthday): 46 EST.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HANDYMAN
10b KIND OF BUSINESS OR INDUSTRY: VARIOUS
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO: UNKNOWN
17. INFORMANT: KIGHT FUNERAL HOME — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Brain Abscesses — INTERVAL BETWEEN ONSET AND DEATH: 11 days
DUE TO (b): Septicemia — " "
DUE TO (c): Lung Abscesses (Colon Bacillus)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 064.4

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Cumberland, Md.

22. DATE SIGNED: June 8, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: JUNE 10, 1967
23c. NAME OF CEMETERY OR CREMATORY: ALLEGANY COUNTY CEMETERY
23d. LOCATION (City or Town) (County) (State): CUMBERLAND, MD.

24 FUNERAL DIRECTOR: BYRON KIGHT — ADDRESS: CUMBERLAND, MD.
25a. REC'D BY REGISTRAR DATE: JUN 14 1967
25b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07532 — 07505

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 148 Wood St.

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
d. STREET ADDRESS: 148 Wood Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: George — Middle: H — Last: Robertson
4. DATE OF DEATH: Month: June — Day: 3 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 17, 1902
9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Allegany
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: George Robertson
14. MOTHER'S MAIDEN NAME: Maude Wilson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO: 220-30-5836
17. INFORMANT: Mrs. George Robertson
Address: Westernport, Md

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Embolus — INTERVAL BETWEEN ONSET AND DEATH: 2 Hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary Artery Disease — 5 Years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 31, 1967 to June 3, 1967, that (I) (we) last saw the deceased alive on June 3 1967, and that death occured at 9:46 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Paul R Wilson M.D.
22b. DATE SIGNED: June 5, 1967
22c. PHYSICIAN'S NAME (Type): Paul R.Wilson M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS: Ashfield St. Piedmont, W.Va.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 7, 1967
23c. NAME OF CEMETERY OR CREMATORY: Philos Cemetery
23d. LOCATION (City, town or county) (State): Westernport, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: W.A. Faulkner for
ADDRESS: Piedmont, W.Va.
25a. REC'D BY REGISTRAR DATE: JUN 7 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 1 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07533

CERTIFICATE OF DEATH

07509

1 PLACE OF DEATH
a COUNTY ALLEGANY
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
c LENGTH OF STAY IN 1b 65 years
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE MARYLAND b COUNTY ALLEGANY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
d. STREET ADDRESS 3 BYRD AVENUE
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First XXXXXXX Middle Leon (Lee) Last ROGAN
4 DATE OF DEATH Month JUNE Day 11 Year 19 67

5 SEX MALE
6 COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH Sept. 30, 1891
9 AGE (In years last birthday) 75 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist Helper-Railroad
10b KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (County & State, or foreign country) Barton, Md.
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Thomas Rogan
14. MOTHER'S MAIDEN NAME Elizabeth Davis

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) War I
16 SOCIAL SECURITY NO
17 INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Arteri-sclerotic CV Disease — Indefinite
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c) Also had aneurysm - aorta

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Operation — 4-2-67 Intestinal Obstruction
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDER-LYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 1, 1967 to 7:00 P.M., 19__, that (I) (we) last saw the deceased alive on 6-11 1967, and that death occurred at ____ M, from causes and on the date stated above

22a SIGNATURE Carlton Brunsfield M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) DR. CARLTON BRUNSFIELD
22d. ADDRESS CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify) Burial
23b DATE THEREOF June 14, 1967
23c NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
23d LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany

24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.
ADDRESS
25a DATE RECEIVED BY REG. STRAR JUN 15 1967 DATE
25b REGISTRAR'S SIGNATURE Charles Judge

14

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07534 07510

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN MARYLAND: 30 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital (40 Minutes)

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): LaVale
d. STREET ADDRESS: 14 Roselawn Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth; Middle: M.; Last: Rorick

4. DATE OF DEATH: Month: June; Day: 5; Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 10, 1912

9. AGE (In years last birthday): 54 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Moorfield, W.Va.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Daniel Coby

14. MOTHER'S MAIDEN NAME: Elise Riggleman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unkown): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: John J. Rorick Address: 14 Roselawn, Ave.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 1201 Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO (b): Coronary Sclerosis — --
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: White at work ☐ Not White at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, off car bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

Address (Street, city, town or county): Cumberland, Maryland

DATE SIGNED: June 5, 1967

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/8/67

22c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery

22d. LOCATION (City, town, or country) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR: Lewis Stein Inc. ADDRESS: Cumb. Md.

24a. REC'D BY REGISTRAR: JUN 9 1967

24b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the [illegible] director 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07535

CERTIFICATE OF DEATH

07511

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 1MO 3WKS1DA.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a. STATE: MARYLAND — b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   d. STREET ADDRESS: RT#3, BEDFORD RD.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: IRA — Middle: C — Last: SAVILLE

4. DATE OF DEATH: Month: JUNE — Day: 18, — Year: 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 3-22-1889

9. AGE (In years last birthday): 78 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: GROCERY

11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ISAC SAVILLE

14. MOTHER'S MAIDEN NAME: ANNA BARNES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO: 233 18 4911

17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 7 wks
DUE TO (b): Arteriosclerotic Cardiovascular Disease — 5 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/7/66, 19__ to 7/14/67, 19__, that (I) (we) last saw the deceased alive on 6/19/67 19__, and that death occurred at 4:40 P.M. from causes and on the date stated above

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS ☒ — MED DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 6/19/67

22c. PHYSICIAN'S NAME (Type): DR, R, J, WILLIAMS

22d. ADDRESS: 122 SO. CENTRE ST, CUMBERLAND, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 20, 1967

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

23d. LOCATION (City or Town) (County) (State): Cumberland, Md.

24. FUNERAL DIRECTOR: Byron Kight — ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR — DATE: JUN 23 1967

25b. REGISTRAR'S SIGNATURE: [signature] Charles Judge

VR A15 (4) M 1/66

1 2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07536 **CERTIFICATE OF DEATH** 07512

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: Maryland b. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg	c. LENGTH OF STAY IN 1b: 60 years
	c. CITY OR TOWN (If outs de corporate limits write RURAL and give nearest town): ~~Frostburg~~ Eckhart, Md.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Miners Hospital	d STREET ADDRESS: Box 46 — e IS RES DENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Lost	4 DATE OF DEATH Month	Day	Year
Marie		Scarpelli	June	17	19 67

5 SEX	6 COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8 DATE OF BIRTH	9 AGE (In years lost birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min
Female	White		Dec. 27, 1885	81 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Italy	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16 SOCIAL SECURITY NO.	17. INFORMANT Address
no		Mr. James Scarpelli, Eckhart, Md.-Son

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute brain Syndrome	
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — (b)	Circulatory disturbance	Instant
DUE TO		
(c)	Cerebral arteriosclerosis	10 yrs.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 10, 19 66, to June 17, 1967, that (I) (we) last saw the deceased alive on June 14 19 67, and that death occurred at 2:40 P.M., from causes and on the date stated above

22a. SIGNATURE	M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐	22b. DATE SIGNED
G Paige Strong		June 19, 1967
22c. PHYSICIAN'S NAME (Type) Dr. G. Paige Strong, M.D.	22d. ADDRESS 167 E. Main St - Frostburg, Md.	

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	June 20, 1967	St. Michael's Cemetery	Frostburg, Md. Allegany

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	JUN 22 1967	J Charles Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07537 Item #6 Film # 7349 - 7/10/67 DS

CERTIFICATE OF DEATH

07513

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 79 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
d. STREET ADDRESS: 516 LOWELL AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROY — Middle T. — Last SHAFFER
4. DATE OF DEATH: Month JUNE — Day 7 — Year 19 67
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-15-88 1888
9. AGE (In years last birthday): 78 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARMAN
10b. KIND OF BUSINESS OR INDUSTRY: RAILROAD
11. BIRTHPLACE (County & State, or foreign country): PENNA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM SHAFFER
14. MOTHER'S MAIDEN NAME: ELLIA SHIPLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO: 705 10 8384
17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): METASTATIC CARCINOMA-GENERALIZED — INTERVAL BETWEEN ONSET AND DEATH: YEARS
DUE TO (b): PROSTATE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour o m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1960 19 to JUNE, 1967, that (I) (We) last saw the deceased alive on JUNE 7 1967, and that death occurred at 2:35P M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 6-8-67
22c. PHYSICIAN'S NAME (Type): DR. G. OVERTON HIMMELWRIGHT
22d. ADDRESS: 133 VA. AVENUE, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: JUNE 10, 1967
23c. NAME OF CEMETERY OR CREMATORY: SUNSET MEMORIAL PARK
23d. LOCATION (City or Town) (County) (State): CUMBERLAND, MD.

24. FUNERAL DIRECTOR: BYRON KIGHT — ADDRESS: CUMBERLAND, MD.
25a. REC'D BY REGISTRAR DATE: JUN 12 1967
25b. REGISTRAR'S SIGNATURE: [signature] Deputy Judge

VR A15 (4)
25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07538

CERTIFICATE OF DEATH

07514

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: W. VIRGINIA — b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIDGELEY, W.VA.
d. STREET ADDRESS: 163 MAIN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First MARY — Middle E — Last SHEPHERD

4 DATE OF DEATH: Month JUNE — Day 6 — Year 1967

5 SEX: FEMALE
6 COLOR OR RACE: WHITE
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 7-15-84
9 AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b KIND OF BUSINESS OR INDUSTRY: OWNNHOME
11 BIRTHPLACE (County & State, or foreign country): W. VIRGINIA
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DANIEL STIENBAUGH
14. MOTHER'S MAIDEN NAME: CHRISTIAN DYCHE

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16 SOCIAL SECURITY NO: NONE
17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral Vascular
DUE TO (b): Diabetes
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
334X
INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/7/54, 19___, to 6/6/67, 19__, that (I) ~~(We)~~ last saw the deceased alive on 6/6/67, 19___, and that death occurred @ 2:45 P.M., from causes and on the date stated above

22a SIGNATURE: [signature] M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 6/8/67
22c PHYSICIAN'S NAME (Type): DR. R. J. WILLIAMS
22d ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: JUNE 9, 1967
23c NAME OF CEMETERY OR CREMATORY: SUNSET, EMORIAL PARK
23d LOCATION (City or Town) (County) (State): CUMBERLAND, MD.

24. FUNERAL DIRECTOR: BYRON KIGHT — ADDRESS: CUMBERLAND, MD.
25a. RECD BY REGISTRAR DATE: JUN 12 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07539

CERTIFICATE OF DEATH

07515

1 **PLACE OF DEATH**
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 32 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2 **USUAL RESIDENCE** (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): FROSTBURG, MD.
d. STREET ADDRESS: 183 S. WATER ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 **NAME OF DECEASED** (Type or print): First FREDERICK — Middle H — Last SHOCKEY

4. **DATE OF DEATH**: Month JUNE — Day 25 — Year 19 67

5 SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-22-00

9 AGE (In years last birthday): 66 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SELF-EMPLOYED

10b KIND OF BUSINESS OR INDUSTRY: TAVERN OPERATOR

11. BIRTHPLACE (County & State or foreign country): PENNA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HERMAN SHOCKEY

14. MOTHER'S MAIDEN NAME: SUSAN WARNER

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO: 215-18-8513

17. **INFORMANT**: MEMORIAL HOSPITAL — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Carcinomatosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Carcinoma - transitional cell - bladder
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Abscess & infection retropubic space -

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5/29/67 to 6/25/67, that (I) (we) last saw the deceased alive on 6/24/1962, and that death occurred at 10:35 A.M., from causes and on the date stated above.

22a. SIGNATURE: W Himmler M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/27/67.

22c. PHYSICIAN'S NAME (Type): DR. WALTER HIMMLER

22d. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: JUNE 28, 1967

23c. NAME OF CEMETERY OR CREMATORY: WHITE OAK CEMETERY

23d. LOCATION (City or Town) (County) (State): SOMERSET, PENNA.

24. FUNERAL DIRECTOR — ADDRESS: JOSEPH R. DURST, SR., FROSTBURG, MD.

25a. REC'D BY REGISTRAR DATE: JUN 29 1967

25b. DATE REGISTRAR SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07540 Item #3 Film #G329 6/67737 pc

CERTIFICATE OF DEATH

07516

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1WK. 1DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLDTOWN
d. STREET ADDRESS: OLDTOWN, MD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First LORENA — Middle A. Shryock — Last ~~Shryock~~ Twigg
4. DATE OF DEATH: Month JUNE — Day 15, — Year 1967

5 SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: March 4, 1895
9 AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HWFE.
10b. KIND OF BUSINESS OR INDUSTRY: Ownhome
11 BIRTHPLACE (County & State, or foreign country): OLDTOWN, MD.
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: CHARLES TWIGG
14. MOTHER'S MAIDEN NAME: HANNAH ~~SHRYOCK~~ Goldsborough

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16 SOCIAL SECURITY NO.: None
17 INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO (b): Hypertensive arteriosclerotic C.V.D. — Since 1960
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus - severe
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year — Hour o m. p m — 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from 3-22-, 19 62 to 5-15-, 19 67 that (I) ~~(we)~~ last saw the deceased alive on 5-14-1967, and that death occurred at 5:00 A.M. P.M. from causes and on the date stated above.

22a SIGNATURE: Wm. F. Williams M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED: 5-15-67
22c PHYSICIAN'S NAME (Type): DR. WM. F. WILLIAMS
22d ADDRESS: 122 S. CENTRE ST, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-18-67
23c NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery
23d LOCATION (City or Town) (County) (State): Cumberland Md.

24 FUNERAL DIRECTOR: Scarpelli Funeral Home — ADDRESS: Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: JUN 20 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

James F. Scarpelli

VR A15 (4)
25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

27541 — 07517

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 4 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 2 DAY 8 HR
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 21 CRESAP DR., BOWLING GREEN
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EVELYN — Middle: MAE — Last: SMITH
4. DATE OF DEATH: Month: JUNE — Day: 21 — Year: 19 67
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐
8. DATE OF BIRTH: 12-01-1907
9. AGE (In years last birthday): 59 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine Opr.
10b. KIND OF BUSINESS OR INDUSTRY: Factory Wkr.
11. BIRTHPLACE (County & State, or foreign country): MONONGAHELA CITY, PA.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: JOHN JAMES CALVERT
14. MOTHER'S MAIDEN NAME: FLORENCE ANN WESTWOOD
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No.
16. SOCIAL SECURITY NO: 215-20-6833
17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septal infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b): Coronary Thrombosis — 1 day
DUE TO (c): Arterio Sclerotic Coronary Artery disease — Long
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Latent diabetes Mellitus, Vaginal repair procedure 6-20-67
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 18, 1967 to June 21, 1967, that (I) (we) last saw the deceased alive on June 20 1967, and that death occurred at 2:55 A.M. from causes and on the date stated above.

22a. SIGNATURE: Dr. Grove — M.D. — ATTENDING PHYS ☒ — MED DIRECTOR ☐ — STAFF PHYS ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): D. B. GROVE, MD.
22d. ADDRESS: 122 SOUTH CENTRE STREET CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/24/67
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR — ADDRESS: H. Wayne George Cumberland, Md.
25a. DATE BY REGISTRAR: JUN 26 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07542 — 07518

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D. O. A. Memorial

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
d. STREET ADDRESS: 237 Paca St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ollie — Middle: Frances — Last: Snyder
4. DATE OF DEATH: Month: June — Day: 27, — Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 18, 1890
9. AGE (In years last birthday): 77 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife,
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Monterey, Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Henry Grogg
14. MOTHER'S MAIDEN NAME: Barbara Sponaugle
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No,
16. SOCIAL SECURITY NO: None
17. INFORMANT — Address: Mrs. Elva Walters, 237 Paca St. Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO
(b): CORONARY SCLEROSIS — ---
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic MD
EXAMINER'S NAME (Type): Benedict Skitarelic, M. D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county): Rt. # 9 Cumberland, Md.
22. DATE SIGNED: 6/27/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7/1/67
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany Md.
24. FUNERAL DIRECTOR — ADDRESS: H. Wayne George Cumberland, Md.
25a. RECD BY REGISTRAR — DATE: JUN 30 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07543

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07519

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in part 1, item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH
a COUNTY: Allegany — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hosp. (D.O.A.)

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a STATE: W. Va. b COUNTY: Mineral
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Ridgeley
d STREET ADDRESS: 168 Main St.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
William	Robert	Spangler	June	8,	19 67

5 SEX	6 COLOR OR RACE	7 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
Male	White	MARRIED ☒	5/16/1899	68 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Textile Plant	Cumberland, Md.	U.S.A.

13. FATHER'S NAME: Robert P. Spangler
14. MOTHER'S MAIDEN NAME: Mary Snyder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes	W.W. # 1	214-07-0005	Mrs. Hallie Spangler	168 Main St. Ridgeley, W.Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY-		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	SUDDEN
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — (b)	CORONARY SCLEROSIS	---
DUE TO		
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Cumb, Md. Rt. # 9
6-8-67 22 DATE SIGNED
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.
Address (Street, city, town or county): Balto. Pike

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town, County, State)
Burial	6/12/67	Davis Memorial Burial Park	Cumberland, Allegany, Md.

24 FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
H. Wayne George	Cumberland, Md.	JUN 14 1967	Charles Junge

VR A15ME (5) 6M 1-67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07544

CERTIFICATE OF DEATH

07521

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1WK, 1DAY, 9HRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MT. SAVAGE
d. STREET ADDRESS: MT. SAVAGE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: HOWARD — Middle: R. — Last: STEVENS

4. DATE OF DEATH: Month: JUNE — Day: 29, — Year: 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-7-1895

9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: RAILROAD

11. BIRTHPLACE (County & State, or foreign country): FROSTBURG, MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: GEORGE STEVENS

14. MOTHER'S MAIDEN NAME: CATHERINE HAGER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO: 712-14-1699

17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Disease
DUE TO (b): Arterio Sclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 1 yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Prostate

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-27-67, 19___, to 6-29-67, 19___ that (I) (we) last saw the deceased alive on 6-29-67 19___, and that death occurred at 11:50 M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7/2/67

22c. PHYSICIAN'S NAME (Type): DR. R.J. WILLIAMS

22d. ADDRESS: 122 SO. CENTRE STREET, CUMBERLAND, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: JULY 2, 1967

23c. NAME OF CEMETERY OR CREMATORY: FROSTBURG MEM. PARK

23d. LOCATION (City or Town) (County) (State): FROSTBURG ALLEG. MD

24. FUNERAL DIRECTOR: John T. Hafer Jr.

ADDRESS: JOHN T. HAFER, JR. - 230 BALTO. AVE. - CUMB., MD

25a. REC'D BY REGISTRAR DATE: JUL 5 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07545

CERTIFICATE OF DEATH

07522

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 2 HRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
d. STREET ADDRESS: 225 BEDFORD ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Girl — Last: TALLMAN

4. DATE OF DEATH: Month: JUNE — Day: 7 — Year: 19 67

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-7-67

9. AGE (In years last birthday): yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours: 2 — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None, (infant)

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES E. TALLMAN

14. MOTHER'S MAIDEN NAME: ~~BONNIE MALON~~ Bonita Malone

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No,

16. SOCIAL SECURITY NO: None

17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Preventable Premature — INTERVAL BETWEEN ONSET AND DEATH
776X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19__ to _____, 19__, that (I) (we) last saw the deceased alive on _____ 19__, and that death occurred at 6:15A M, from causes and on the date stated above

22a. SIGNATURE: Leland Ransom — M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7 June 67

22c. PHYSICIAN'S NAME (Type): DR. LELAND RANSOM

22d. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/8/67

23c. NAME OF CEMETERY OR CREMATORY: Fort Ashby Cem.

23d. LOCATION (City or Town) (County) (State): Fort Ashby, Mineral W. Va.

24. FUNERAL DIRECTOR: H. Wayne George — ADDRESS: Cumberland, Maryland

25a. REC'D BY REGISTRAR DATE: JUN 12 1967

25b. REGISTRAR'S SIGNATURE: J Charles Yuggo

1

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07546

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07523

1 PLACE OF DEATH
a COUNTY: ALLEGANY
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c LENGTH OF STAY IN 1b: D O A
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MINERS HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: MARYLAND
b COUNTY: ALLEGANY
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): ECKHART
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First MARIE Middle S. Last VALENZANO
4 DATE OF DEATH: Month JUNE Day 15, Year 19 67

5 SEX: FEMALE
6 COLOR OR RACE: WHITE
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: DEC. 28, 1881
9 AGE (In years last birthday) 85 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WORK
10b KIND OF BUSINESS OR INDUSTRY: OWN HOME
11 BIRTHPLACE (State or foreign country): TORINO, ITALY
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: JOSEPH P. SASSONE
14 MOTHER'S MAIDEN NAME: MATILDA GAVIATI

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16 SOCIAL SECURITY NO: 213-09-6584-D
17 INFORMANT Address: LOUIS VALENZANO, ECKHART, MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary Sclerosis — ---
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22 DATE SIGNED: June 15, 1967
Address (Street city town or county): Cumberaland, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 6-19-67
23c NAME OF CEMETERY OR CREMATORY: ST. MICHAELS CEMETERY
23d LOCATION (City or Town) (County) (State): FROSTBURG, MD.

24 FUNERAL DIRECTOR ADDRESS: JOSEPH R. DURST, SR., FROSTBURG, MD.
25a RECD BY REGISTRAR DATE: JUN 20 1967
25b REGISTRAR'S SIGNATURE: Charles Jorge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07547

CERTIFICATE OF DEATH

07524

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 WK. ½DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL, CUMBERLAND

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 904 MICHIGAN AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ROBERT; Middle: W.; Last: (Vandegrift) VANDEGRIFT

4. DATE OF DEATH: Month: JUNE; Day: 17; Year: 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 3-7-1917

9. AGE (In years last birthday): 50 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: VIKING INC.

11. BIRTHPLACE (County & State, or foreign country): CUMB, MD.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: WILLIAM H. (Vandegrift) VANDEGRIFT

14. MOTHER'S MAIDEN NAME: MARY L. SMITH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: 214-05-6001

17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CEREBRAL EDEMA — INTERVAL BETWEEN ONSET AND DEATH: 7 DAYS
DUE TO
(b): PATHOLOGIC INTOXICATION WITH EPILEPTOID COMPLICATIONS
DUE TO
(c): ACUTE-CHRONIC- ALCOHOLISM

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from JUNE 10, 1967 to JUNE 17 1967, that (I) (We) last saw the deceased alive on JUNE 16 1967, and that death occurred at 12:23 AM, from causes and on the date stated above

22a. SIGNATURE M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: JUNE 17 1967

22c. PHYSICIAN'S NAME (Type): DR. G. OVERTON HIMMELWRIGHT

22d. ADDRESS: 133 VIRGINIA AVENUE, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/19/67

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland

24. FUNERAL DIRECTOR ADDRESS: H. Lee Silcox Cumberland, Maryland 21502

25a. DATE RECEIVED BY REGISTRAR: JUN 20 1967

25b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07548. **CERTIFICATE OF DEATH** 07525

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (a) 25M 1/67

1. PLACE OF DEATH a. COUNTY: ALLEGANY	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND	c. LENGTH OF STAY IN 1b: 67 DAYS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL	d. STREET ADDRESS: LOWER CONSOLE RD. e. IS RESIDENCE ON A FARM? YES ☐ NO ☐
3. NAME OF DECEASED (Type or print): First MARY Middle E. Last WALBERT	4. DATE OF DEATH: Month JUNE Day 2, Year 19 67
5. SEX: FEMALE	6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: 6-24-1885
9. AGE (In years last birthday): 81 yrs	IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (County & State, or foreign country): GILMORE, MARYLAND	12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: SAMUEL BEAMAN	14. MOTHER'S MAIDEN NAME: HESTER EDWARDS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO: 213-09-6589A
17. INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 week

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b) Subacute Myocardial Infarction — 7 weeks

DUE TO (c) Arteriosclerotic cardiovasaular disease — yeers

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma of the bladder (urinary)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 27, 1967 to June 2, 1967, that (I) (we) last saw the deceased alive on June 2, 1967, and that death occurred at 6:25 A.M., from causes and on the date stated above.

22a. SIGNATURE: Wyand F. Doerner Jr. M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐		22b. DATE SIGNED: June 5, 1967
22c. PHYSICIAN'S NAME (Type): DR. WYAND F. DOERNER, Jr.	22d. ADDRESS: 414 N. MECHANIC ST., CUMBERLAND, MD.	

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE THEREOF: JUNE 4 '67	23c. NAME OF CEMETERY OR CREMATORY: FBG. MEMORIAL PARK	23d. LOCATION (City or Town): FROSTBURG, MD.	(County) (State)
24. FUNERAL DIRECTOR: JOSEPH R. DURST, SR.,	ADDRESS: FROSTBURG, MD.	25a. RECD. BY REGISTRAR DATE: JUN 7 1967	25b. REGISTRAR'S SIGNATURE: [illegible] Judge	

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07543

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C7526

1 PLACE OF DEATH
a COUNTY: Allegany — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 45 years
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Residence-Mexico Farms

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE: Maryland — b COUNTY: Allegany
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cumberland
d STREET ADDRESS: Mexico Farms
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

00

3 NAME OF DECEASED (Type or print): First LENWOOD — Middle — Last WALKER
4 DATE OF DEATH: Month June — Day 25 — Year 1967

5 SEX: Male
6 COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: June 10,1887
9 AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carman
10b KIND OF BUSINESS OR INDUSTRY: Railroad
11 BIRTHPLACE (State or foreign country): Points of Rock, Md.
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Eli Walker
14 MOTHER'S MAIDEN NAME: Sarah Barrett

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16 SOCIAL SECURITY NO:
17 INFORMANT — Address: Mr. Raymond C. Walker Mexico Farms

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): CORONARY SCLEROSIS — ----
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c TIME OF INJURY Month, Day, Year Hour o'clock a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: June 25,1967
EXAMINER'S NAME (Type): Dr. Benedict Skitarelic, M.D.
Address (Street, city, town, or county): Rt.9 Cumberland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: June 28,1967
23c NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
23d LOCATION (City or town) (County) (State): Cumberland, Md. Allegany

24 FUNERAL DIRECTOR — ADDRESS: James F. Scarpelli, Cumberland, Md.
25a RECD BY REGISTRAR DATE: JUN 27 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then (press) remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

97550

CERTIFICATE OF DEATH

07527

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miner's Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md. — b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Grantsville (Rural)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ada — Middle: May — Last: Wilburn

4. DATE OF DEATH: Month: June — Day: 14 — Year: 19 67

5. SEX: F.

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 3, 1886

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Jennings, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Hoover

14. MOTHER'S MAIDEN NAME: Sarah Bittinger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO: --

17. INFORMANT: Address: Denzil Wilburn, Grantsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Brain Syndrome — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Circulatory Disturbance — 7 days
DUE TO
(c): Cerebral Arteriosclerosis — 5 years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 9, 1967, to June 14, 1967, that (I) (we) last saw the deceased alive on June 13 1967, and that death occurred at 1:00 AM, from causes and on the date stated above

22a. SIGNATURE: G. Paige Strong — M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: June 14, 1967

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/16/67

23c. NAME OF CEMETERY OR CREMATORY: Hoover Cemetery

23d. LOCATION (City or Town) (County) (State): Grantsville, Garrett, Md.

24. FUNERAL DIRECTOR: Keith Mumma — ADDRESS: Grantsville, Md.

25a. REC'D BY REGISTRAR DATE: JUN 16 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07551 — **CERTIFICATE OF DEATH** — 07528

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c LENGTH OF STAY IN 1b: 11/3/1958
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Allegany County Infirmary

2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a STATE: Maryland — b COUNTY: Allegany
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d STREET ADDRESS: 645 Columbia Avenue
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth — Middle: Rebecca — Last: Wilkins
4. DATE OF DEATH: Month: June — Day: 10, — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/18/1882
9. AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State or foreign country): West Virginia
12 CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: George Washington Shaw
14. MOTHER'S MAIDEN NAME: Marcella J. Sharp
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16 SOCIAL SECURITY NO: 220-03-7193
17 INFORMANT: P.O.Box 599, Address: Cumberland, Md. — Allegany County Infirmary records.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease
DUE TO (b): Myocardial failure
DUE TO (c): Generalized Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/3/58, 19__ to 6/10/67, 19__, that (I) (we) last saw the deceased alive on 6/9/67, 19__, and that death occurred at 8:00 M, from causes and on the date stated above.

22a. SIGNATURE: George M. Simons M.D — ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒
22b DATE SIGNED: 6/10/1967
22c. PHYSICIAN'S NAME (Type): George M. Simons, M. D.
22d ADDRESS: Memorial Hospital, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jun. 12, 1967
23c NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Md.
24 FUNERAL DIRECTOR: William G. Kight — ADDRESS: Cumberland, Md.
25a REC'D BY REGISTRAR DATE: JUN 14 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07552

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07529

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital D.O. A.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland Maryland
d. STREET ADDRESS: 1204 National Highway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas; Middle: Edward; Last: Williamson

4. DATE OF DEATH: Month: June; Day: 17; Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 4, 1911

9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ass't Vice President, Kelly Springfield

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Thomas, West Virginia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Arthur Williamson

14. MOTHER'S MAIDEN NAME: Edith Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Wife: Clara A Williamson, Cumberland, Md.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis, Left — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Sclerosis
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: June 17, 1967

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

Address (Street, city, town, or cou: Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 20, '67

23c. NAME OF CEMETERY OR CREMATORY: St. Peters & Paula

23d. LOCATION (City, town or county) (State): Cumberland, Maryland

24. FUNERAL DIRECTOR: Lewis Stein, Inc.
ADDRESS: Lewis Stein Inc. Cumb Md

25a. RECD BY REGISTRAR: JUN 21 1967
DATE

25b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film #G389 6/8/67 pc

07553

CERTIFICATE OF DEATH

07530

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1WK. 11HRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 433 BOND STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NINA Middle J. Last WILSON

4. DATE OF DEATH: Month JUNE Day 1, Year 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-25-1918

9. AGE (In years last birthday): 49 yrs.

IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HWFE.

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): KENTUCKY

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JACK GRACIE

14. MOTHER'S MAIDEN NAME: CAMPBELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 220 10 1848

17. INFORMANT: Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma Sigmoid Colon. — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO (b): 1533
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ___, 19__ to ___, 19__, that (I) (we) last saw the deceased alive on 6/1/1967, and that death occurred at 4:40 A.M. from causes and on the date stated above.

22a. SIGNATURE: Andrew Stasko M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/1/67

22c. PHYSICIAN'S NAME (Type): DR. ANDREW STASKO

22d. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: JUNE 3, 1967

23c. NAME OF CEMETERY OR CREMATORY: ZION MEMORIAL PARK**

23d. LOCATION (City or Town) (County) (State): CUMBERLAND, MD.

24. FUNERAL DIRECTOR: BYRON KIGHT ADDRESS: CUMBERLAND, MD.

25a. REC'D BY REGISTRAR DATE: JUN 5 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge